

**AGENDA
Tompkins County Board of Health
Rice Conference Room
Tuesday, August 27, 2013
12:00 Noon**

12:00 I. Call to Order

12:01 II. Privilege of the Floor – Anyone may address the Board of Health (max. 3 mins.)

12:04 III. Approval of July 9, 2013 Minutes (2 mins.)

12:06 IV. Financial Summary (9 mins.)

12:15 V. Old Business (15 mins.)

Administration

Children with Special Care Needs

Medical Director's Report

County Attorney's Report

Division for Community Health

Environmental Health

12:30 VI. New Business

12:30 ***Environmental Health*** (40 mins.)

Enforcement Action:

1. Resolution #12.17.29 – revised - Hanshaw Village Mobile Home Park, T-Dryden, Violation of Subpart 5-1 and Part 17 of the New York State Sanitary Code (MHP/Water) (5 mins.)

2. Resolution #13.18.15 – Beaconview Mobile Home Park, T-Dryden, Violation of Subpart 5-1 of the New York State Sanitary Code (Water) (5 mins.)

3. Resolution #13.18.10 – J-A-M Mobile Home Park, T-Lansing, Violation of Subpart 5-1 of the New York State Sanitary Code (Water) (10 mins.)

4. Resolution #13.14.11 – John Joseph Inn and Elizabeth Restaurant, T-Lansing, Violation of Subpart 5-1 of the New York State Sanitary Code (Water) (5 mins.)

5. Resolution #13.11.17 – Lao Village, T-Ulysses, Violation of Part 14-2 of the New York State Sanitary Code (Temporary Food Service) (10 mins.)

6. Resolution #13.20.16 – Heidi Pane/Leisure Lane, T-Dryden, Violation of Article VI of the Tompkins County Sanitary Code (Sewage) (5 mins.)

1:10 ***Adjournment***

**Board of Health
July 9, 2013
12:00 Noon
Rice Conference Room**

Present: Will Burbank; Brooke Greenhouse; James Macmillan, MD, President; Patrick McKee; and Janet Morgan, PhD

Staff: Sylvia Allinger, Director of CSCN; Liz Cameron, Director of Environmental Health; Sigrid Connors, Director of Patient Services; Brenda Grinnell Crosby, Public Health Administrator; William Klepack, MD, Medical Director; Jonathan Wood, County Attorney; and Shelley Comisi, Keyboard Specialist

Excused: Amy DiFabio, MD; Michael McLaughlin, Jr.; Patricia Meinhardt, MD; and Frank Kruppa, Public Health Director

Privilege of the Floor: No one was present for Privilege of the Floor.

Dr. Macmillan called the regular meeting of the Board of Health to order at 12:09 p.m.

Approval of June 11, 2013 Minutes: Dr. Morgan moved to approve the minutes of the June 11, 2013 meeting as written; seconded by Mr. Greenhouse; carried unanimously.

Financial Summary: Ms. Grinnell Crosby did not have a report for the month but should have one prepared for August.

Administration Report: Mr. Kruppa was absent from the meeting.

It was noted the Board will be meeting the fourth Tuesday of the month beginning in August; the next meeting to be held August 27th. An updated schedule of meeting dates will be sent to members.

Medical Director's Report: Dr. Klepack invited questions and/or comments regarding his written report that included an article discussing a 5-tier health impact pyramid as a framework for public health action.

Dr. Morgan noted there was no mention of gun violence as a public health issue and thought it was a glaring omission.

Dr. Klepack commented the pyramid is an important hierarchy to begin thinking about public health interventions. Most physicians are involved at the level of providing information to the individual in an attempt to persuade the person to make changes. It is challenging when dealing with strongly rooted cultural behaviors such as the current epidemic of obesity.

Dr. Macmillan referred to the base of the pyramid representing socioeconomic variables. These variables include poverty and education levels which are social determinants of health. Data from developing countries supports the idea that educating

the population will improve economic viability. In the United States, there is a financial burden on students wanting to obtain additional education and/or training. It is important to address the issue and encourage education in a cost-effective way. Another policy issue to consider is how public health can impact behaviors that are not within the traditional purview of public health. There is a need to be thinking “outside the box” while trying to be efficient with financial resources.

Mr. Greenhouse thought the article was fascinating but wondered how the concept could be implemented. Dr. Klepack responded local and state health units can float ideas. If there is public reaction, then it must be determined whether there is political support for regulation. Society must decide what is tolerable in the discussion of individual choice versus regulation.

Dr. Klepack stated the hydrofracking issue is an example of the Board of Health enacting the pyramid’s hierarchy. After reviewing the matter, the Board issued a statement in an effort to assist New York State Department of Health (NYSDOH) prepare its health impact assessment of hydrofracking. Based on that assessment, the New York State Department of Environmental Conservation (NYSDEC) may modify regulations governing the process that will result in the public health risk being eliminated or reduced.

Mr. McKee thought the health impact pyramid promotes a broader view of public health. Unemployment and education are public health issues to be considered. The fact that resources directed at the top of this pyramid have the least impact suggests the need for setting public health policy.

Dr. Macmillan noted traditionally efforts have been directed toward the top of the pyramid. Some of the emphasis is turning away from clinical care delivery; however, access to medical care is not universal. There will be individuals dependent upon someone caring about their needs. Taking a broader view makes sense but empowering the public health sector to have some impact on policy remains a concern.

Division for Community Health Report: Ms. Connors had no additions to her written report.

Children with Special Care Needs Report: Ms. Allinger had nothing to add to her report.

County Attorney’s Report: Mr. Wood stated he had nothing to report.

Environmental Health Report: Ms. Cameron reported the application of endothall for treating hydrilla in Cayuga Inlet is scheduled for July 16th.

Approval of Licensed Home Care Services Agency (LHCSA) policy and procedure revisions: Ms. Connors explained the following three policies provide direction to the LHCSA program.

1. **Admission, Plan of Care and Discharge for Maternal-Child, MOMS Clients:** Covers the admission, plan of care and discharge procedures for clients.
2. **Client Services:** Outlines the kind of services to be provided.
3. **Medical Orders:** Describes the process and timelines for medical orders.

Mr. Greenhouse moved to accept the three policies as written; seconded by Dr. Morgan.

Mr. Greenhouse noted the second sentence of the first policy states clients will not be denied service based on an inability to pay. He asked if there are mechanisms in place to help clients obtain financial assistance. As a part of the billing process, Ms. Connors replied staff refers clients to any programs for which they may be eligible. Although clients will not be denied service, they may be asked to pay according to a sliding-fee scale or payment plan.

Dr. Morgan referred to the first policy “Plan of Care Procedure” that includes a list of assessments and wondered whether it should include goals and implementation interventions. Ms. Connors responded the MOMS program gives specific direction to each of those areas in a separate policy in the MOMS manual. Since there must be separate manuals for the MOMS program and the LHCSA, she is matching the standards of each to avoid creating duplicate policies. For clarity, she could add the specific policies to the “References” section on page two.

Dr. Morgan noticed the need for palliative care appears in blue font under the “Plan of Care Procedure” section in the first policy. To obtain the LHCSA license, Ms. Connors explained the policies went through an internal review followed by a NYSDOH review. New regulations were passed so this requirement was added. The blue font indicates the tracking of edits.

The time requirement in the third policy states medical orders shall be authenticated by an authorized practitioner within 30 days. Ms. Connors added if that medical authorization is not obtained within the timeframe of the insurance company, the claim cannot be submitted. After 90 days, the Health Department cannot bill.





























The vote to approve the three policies, as written, carried unanimously.

Adjourn to Executive Session: At 12:30 p.m. Mr. Burbank moved to adjourn to Executive Session for the purpose of discussing a personnel matter related to the 2014 budget; seconded by Mr. McKee; and carried unanimously.

Out of Executive Session: At 1:00 p.m. Mr. Greenhouse moved to adjourn from Executive Session, seconded by Dr. Macmillan, and carried unanimously.

Adjournment: At 1:07 p.m. Dr. Macmillan moved to adjourn the meeting; seconded by Mr. Greenhouse; and carried unanimously.

Dashboard Display thru July 2013

	Expenditures	Revenues
Health Department		
Mandates		
Non-Mandates		
Preschool Special Education		
Plng. & Coord. (Health)		
Women, Infants & Children		
Occupational Hlth.& Sfty.		
Medical Examiner		
Vital Records		
Division For Community Health		
Medical Examiner Program		
Plng. & Coord. Of C.S.N.		
Phys.Handic.Chil.Treatmnt		
Early Intervention (0-3)		
Environmental Health		
Public Health State Aid		

LAST REFRESH: August 16, 2013

EXPENDITURES

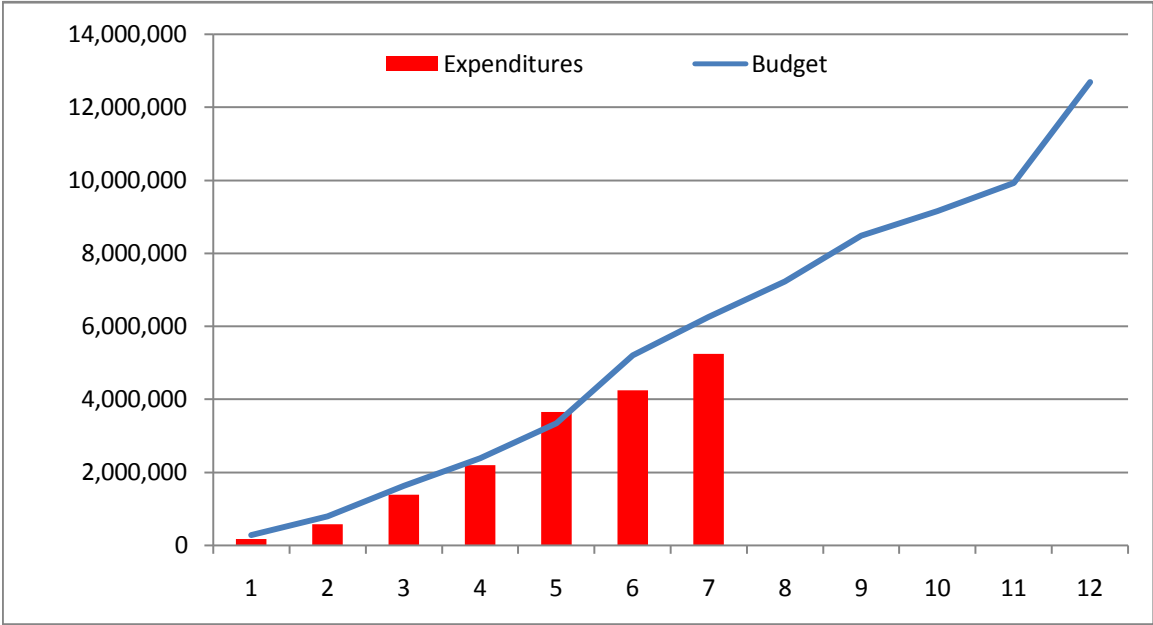
Cumulative to date compared to budget (over budget by more than 15% = Red, between 110% and 115% of budget = Yellow, below 110% of budget = Green)

REVENUES

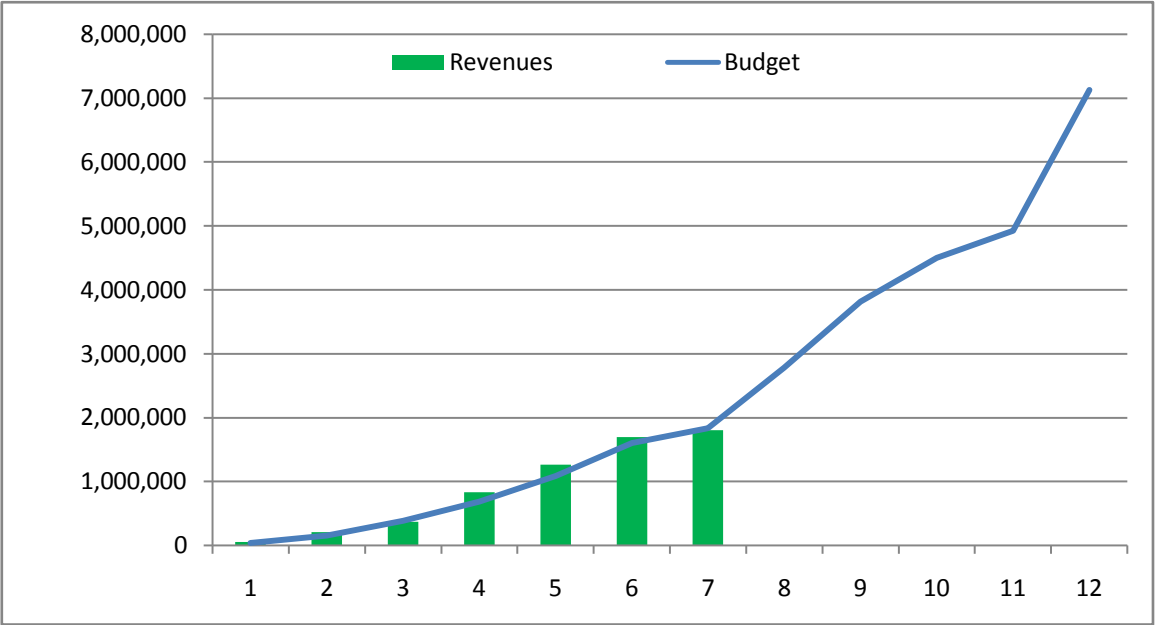
Cumulative to date compared to budget (over = Green, above 90% of budget = Yellow, below 90% of budget = Red)

Tompkins County Health Department

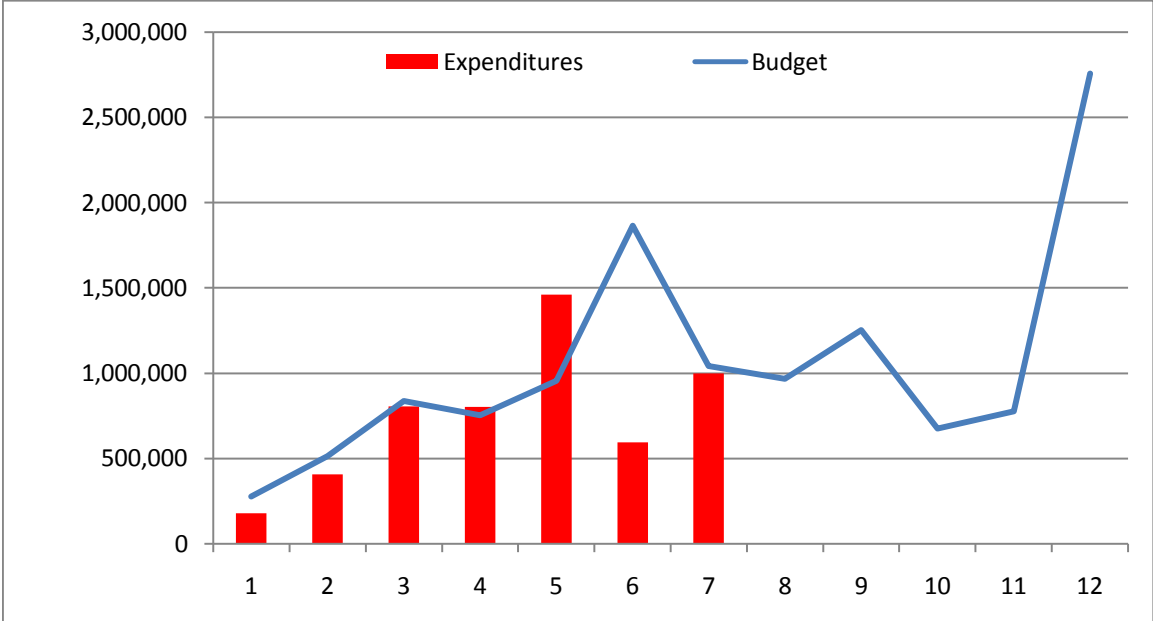
Cumulative Expenditures thru July 2013



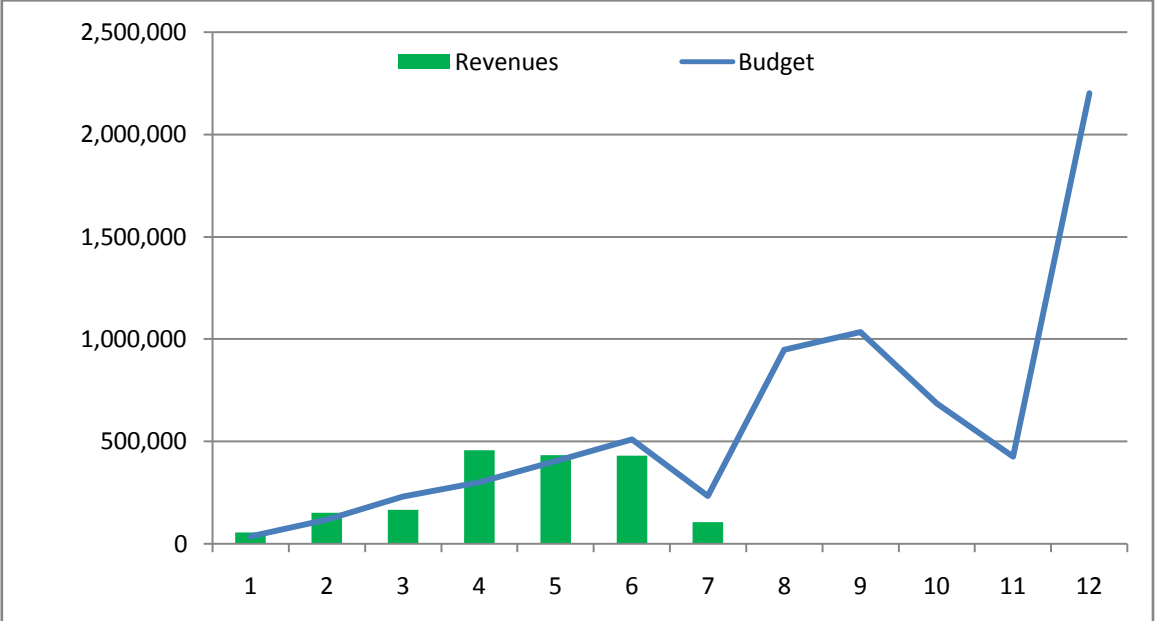
Cumulative Revenues thru July 2013



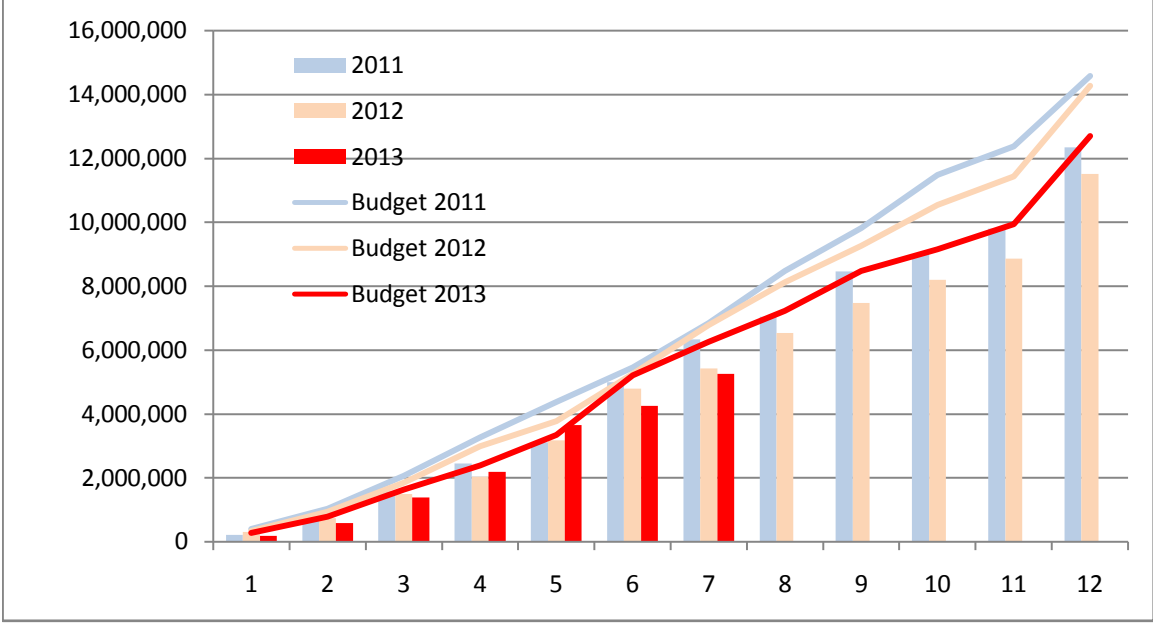
2013 Expenditures by month thru July



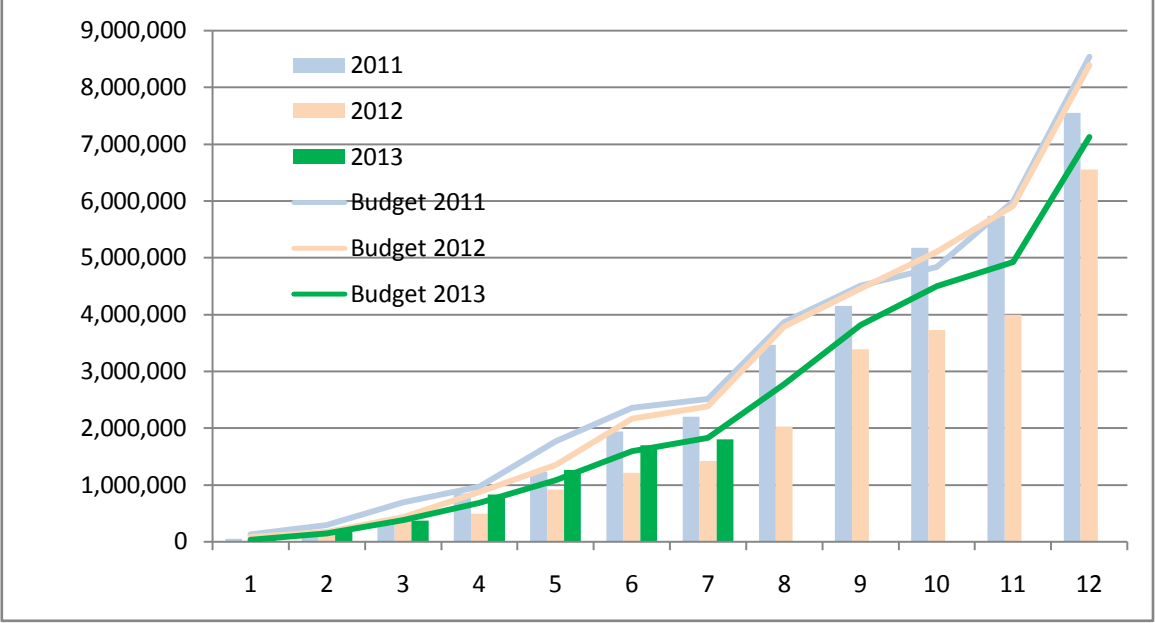
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

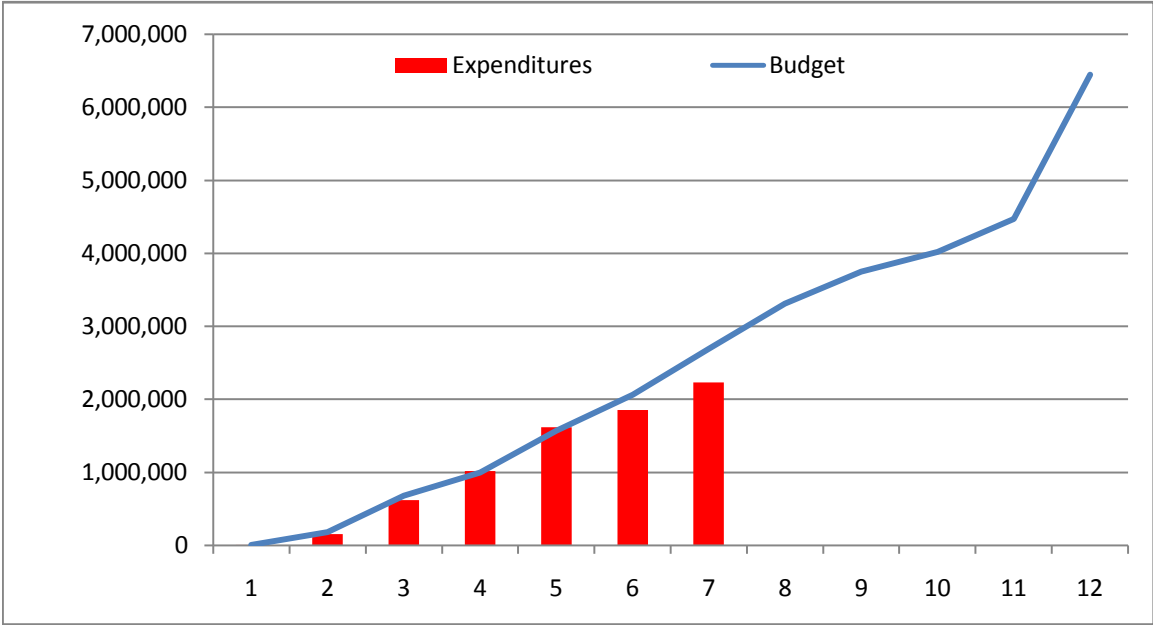


The budget line for each graph is based on the average of the prior two years actuals in a given month as a percent of the total applied to the current years budget.

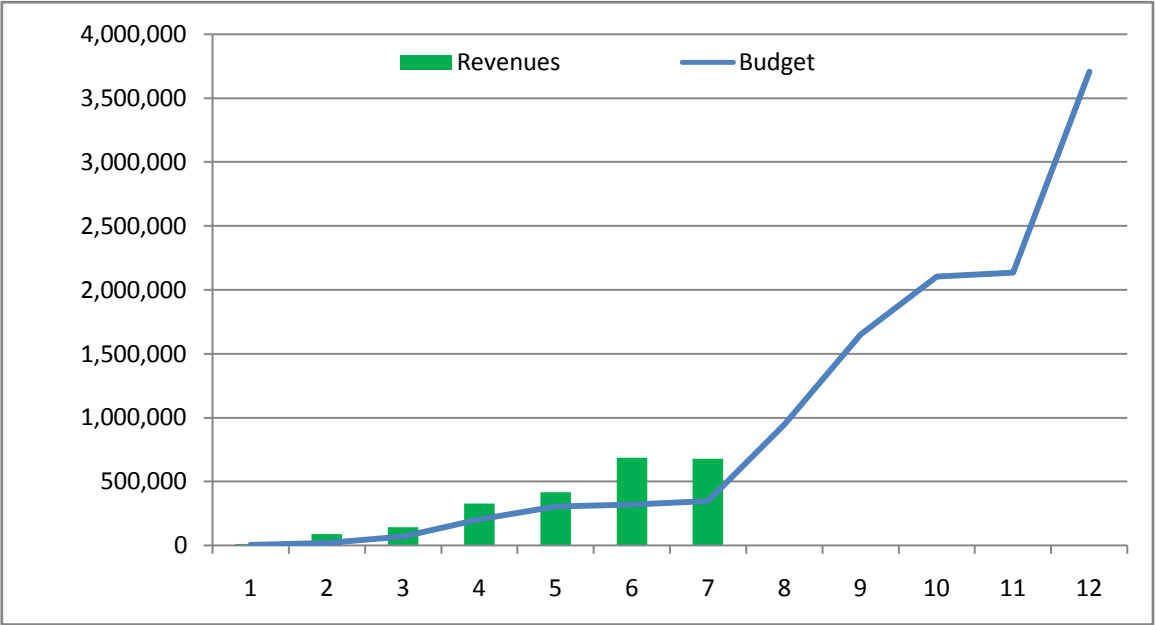
Notes:

Health Department Mandate Accounts

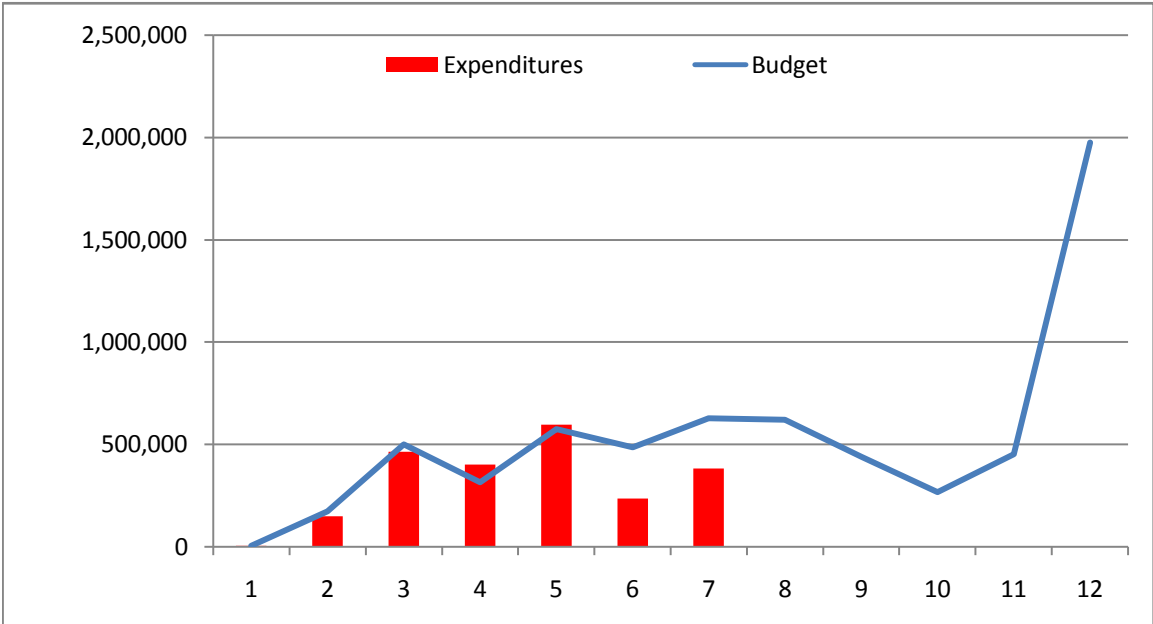
Cumulative Expenditures thru July 2013



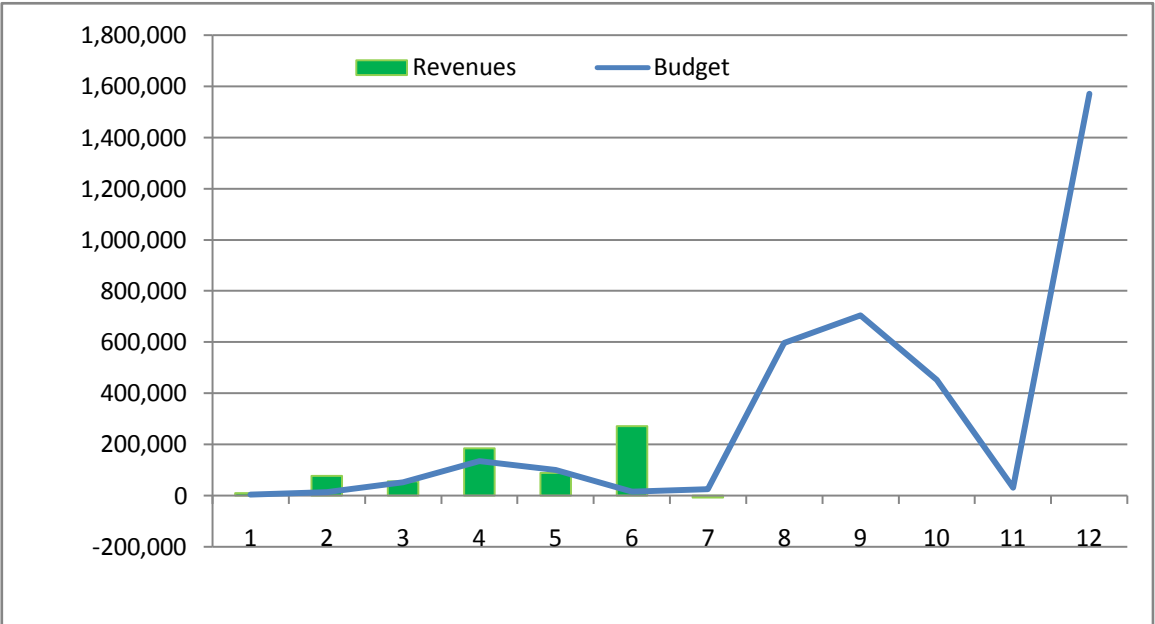
Cumulative Revenues thru July 2013



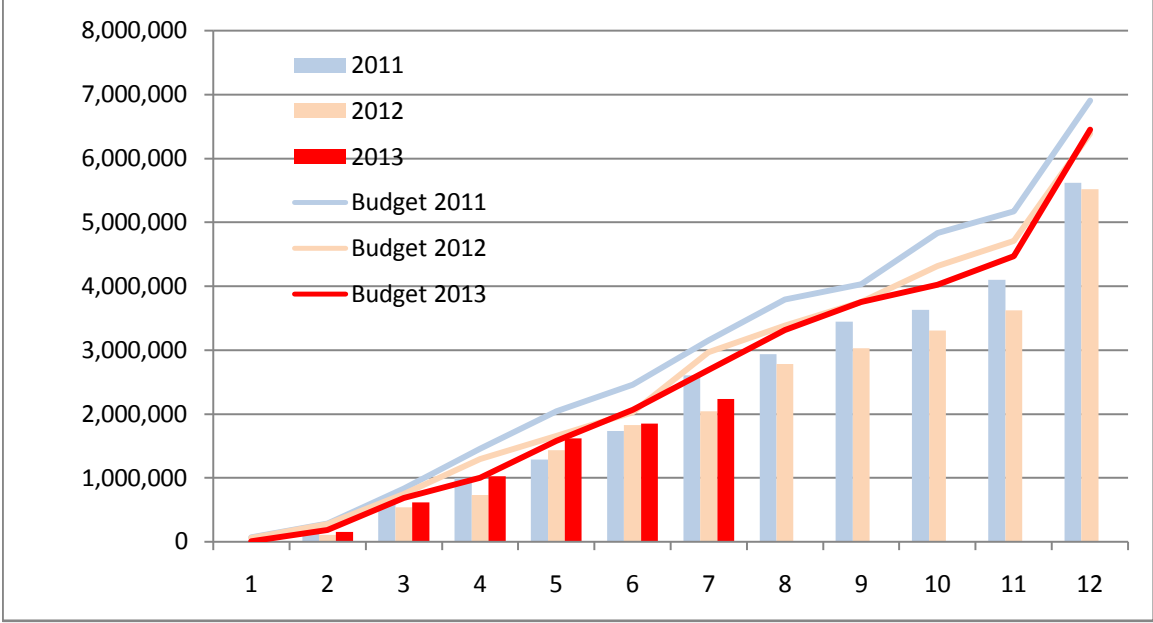
2013 Expenditures by month thru July



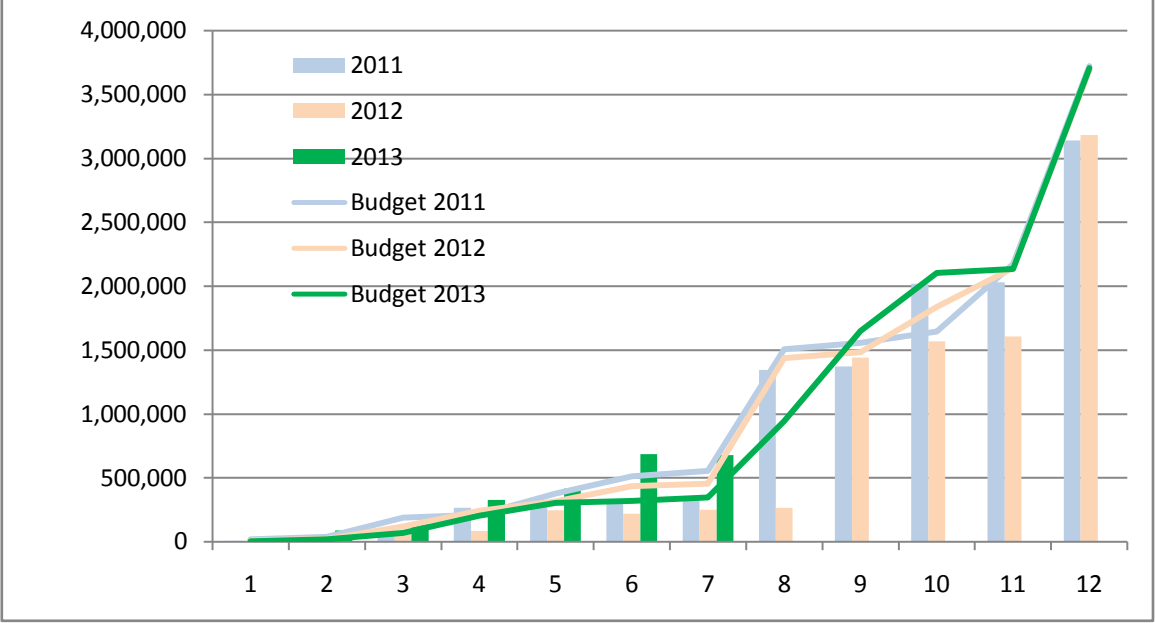
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

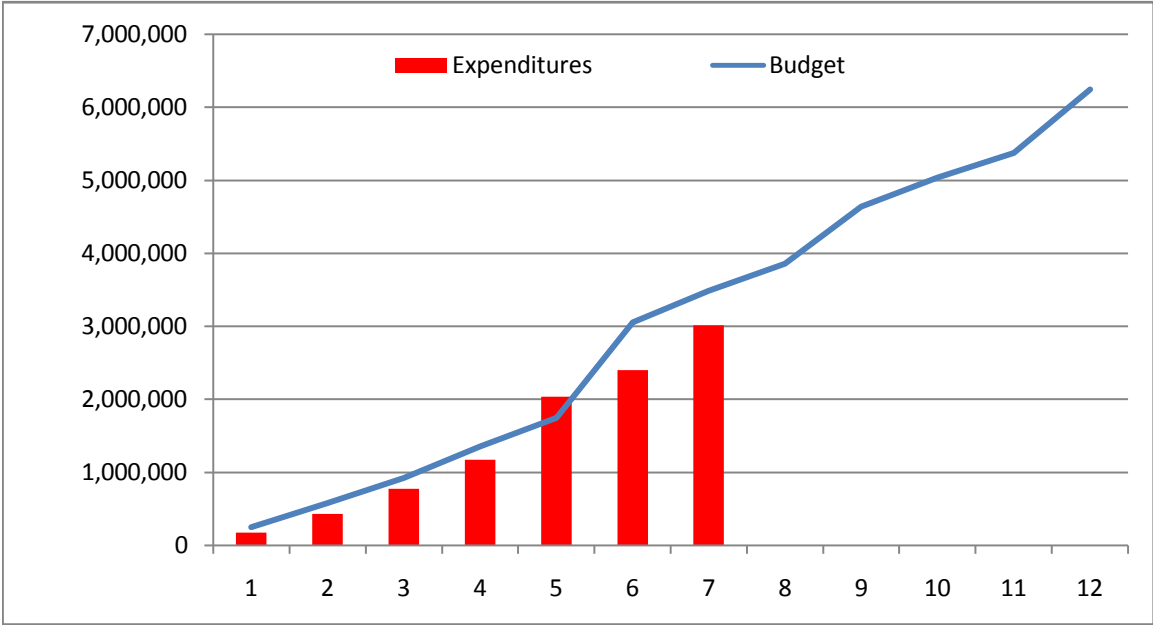


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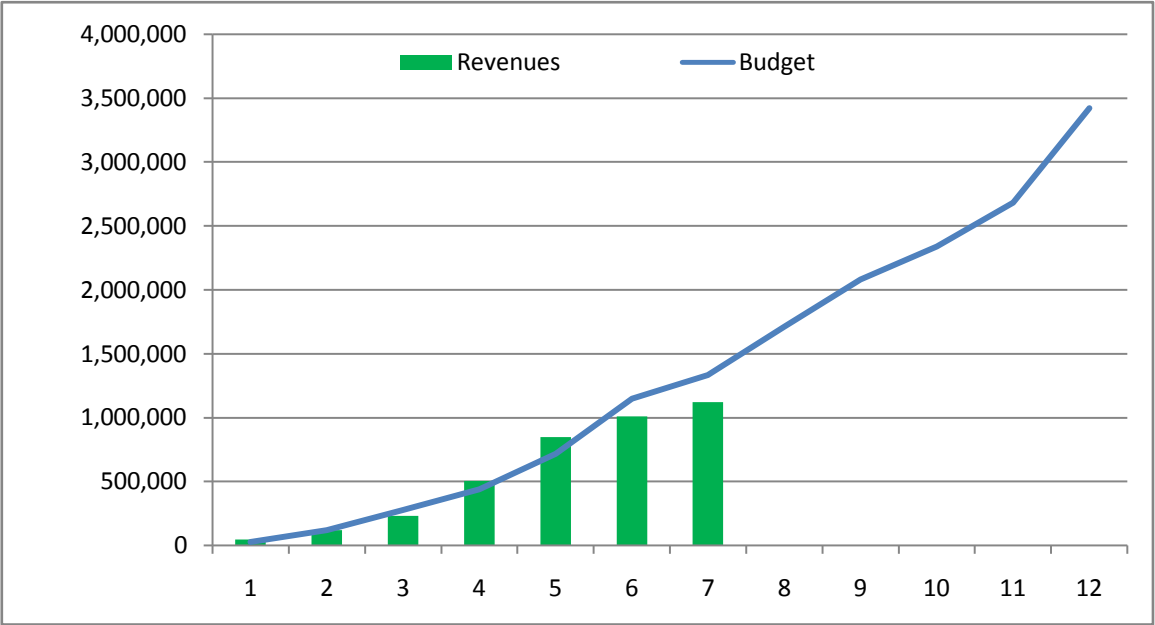
Notes:

Health Department Non-Mandate Accounts

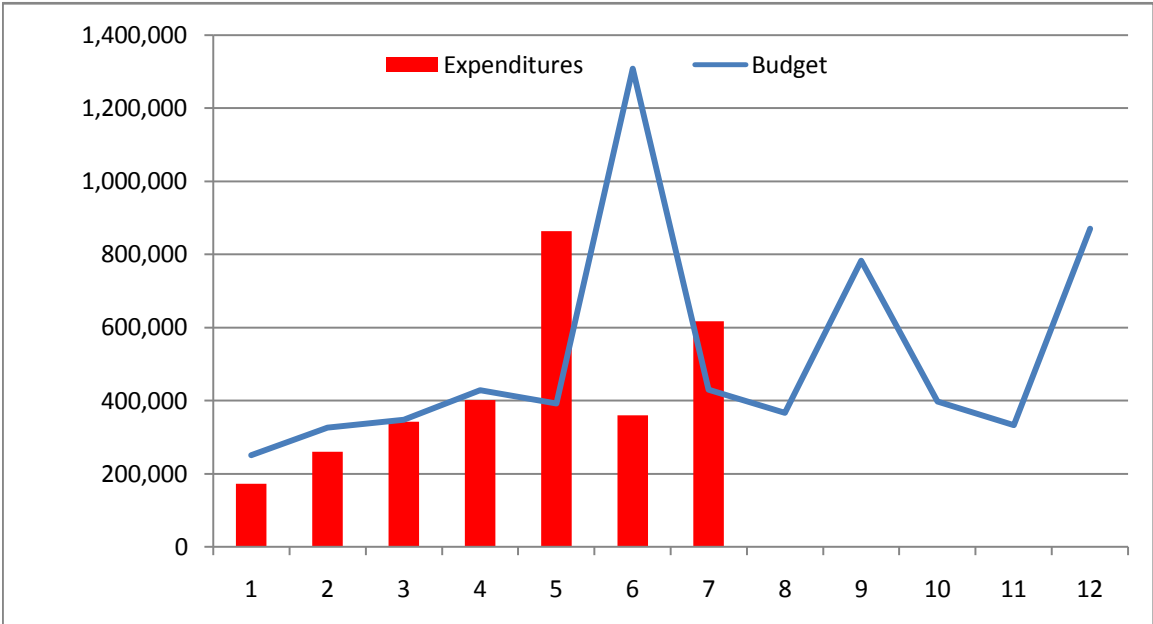
Cumulative Expenditures thru July 2013



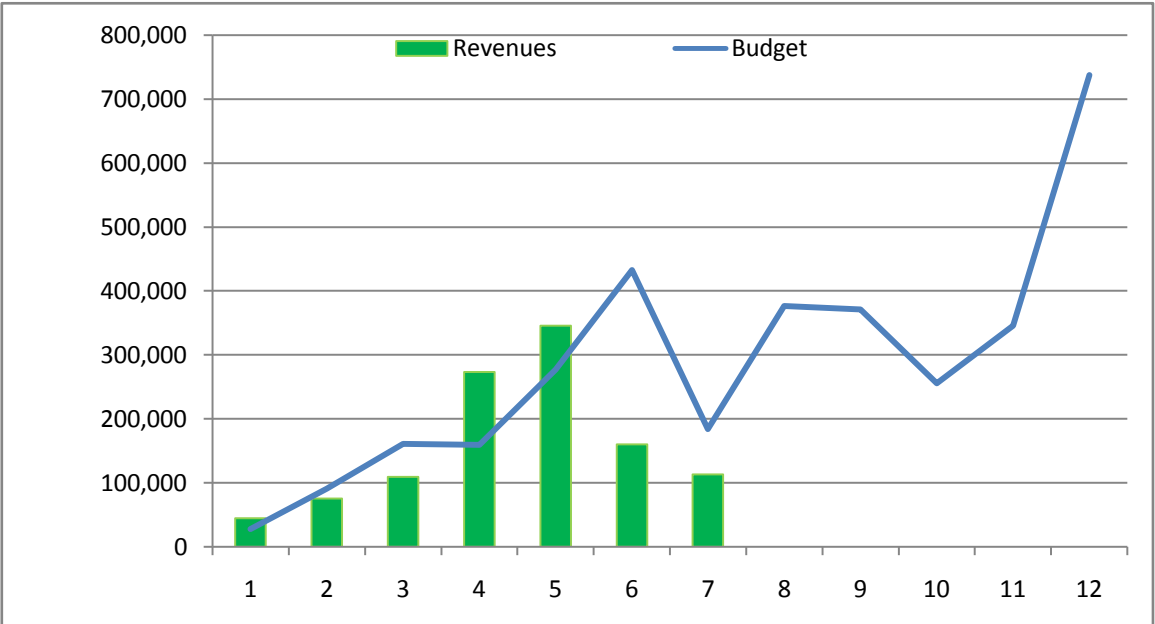
Cumulative Revenues thru July 2013



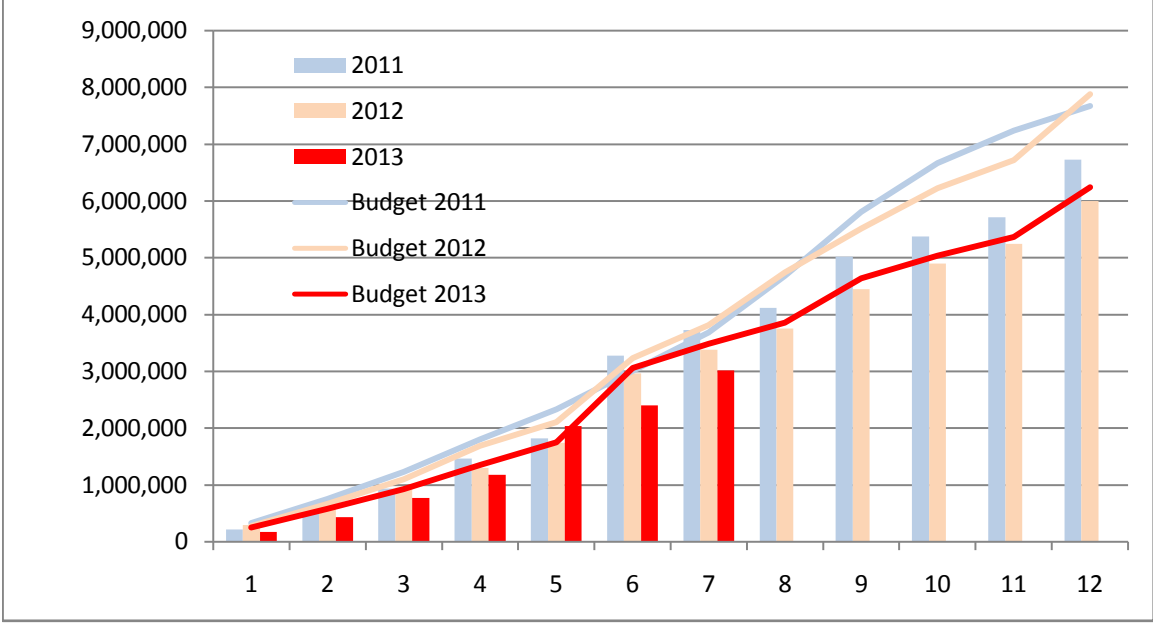
2013 Expenditures by month thru July



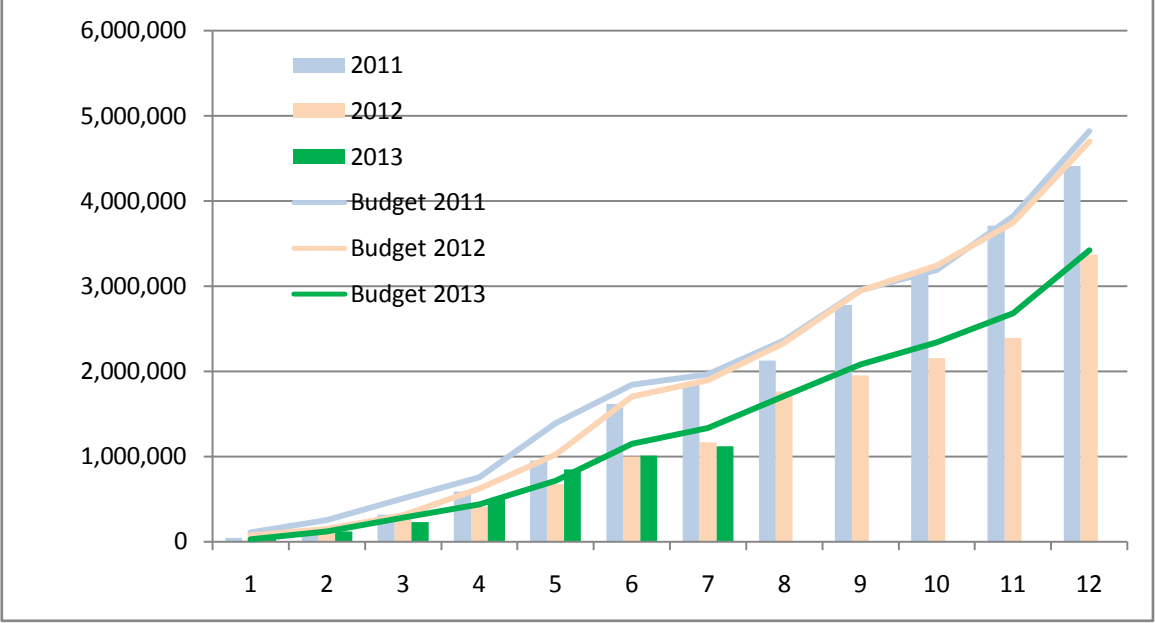
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

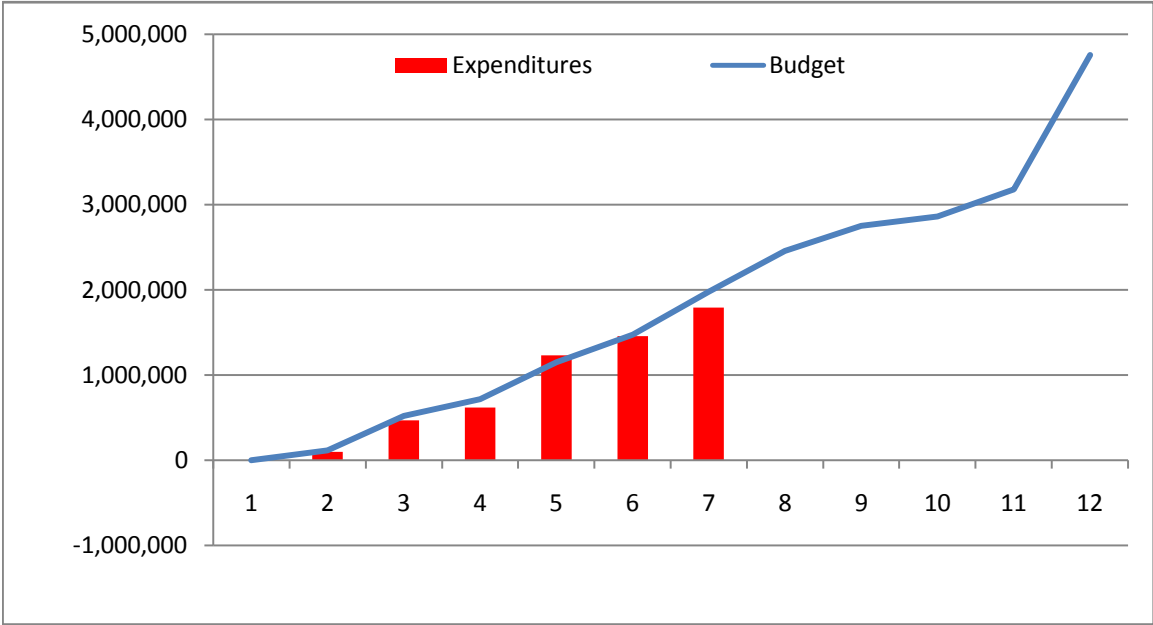


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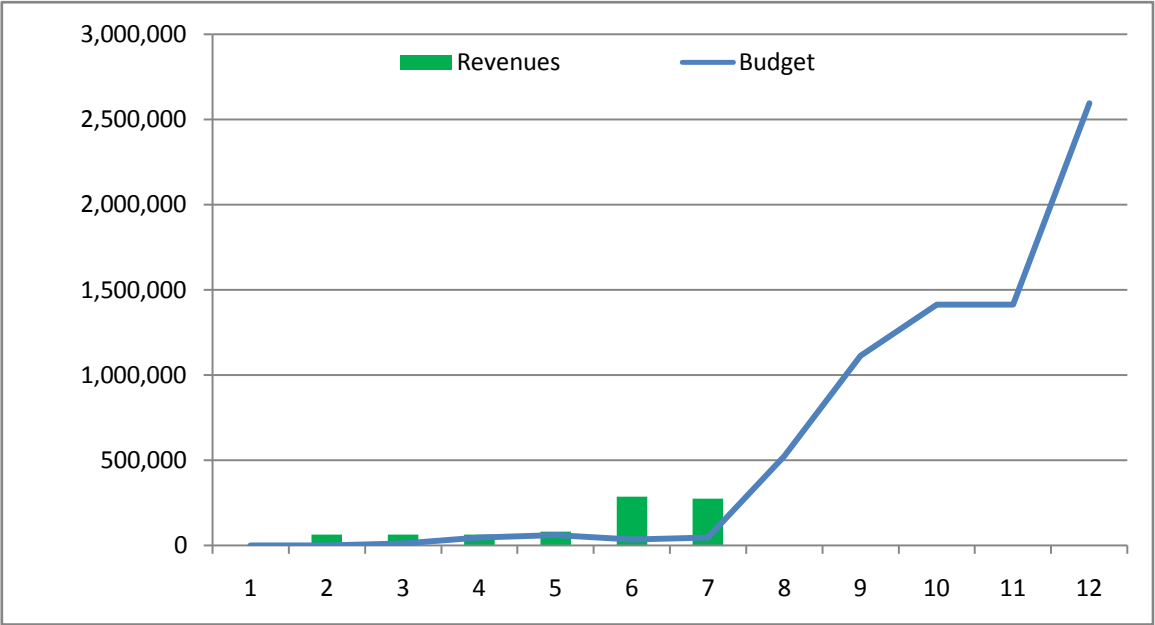
Notes:

Health Department - Preschool Special Education

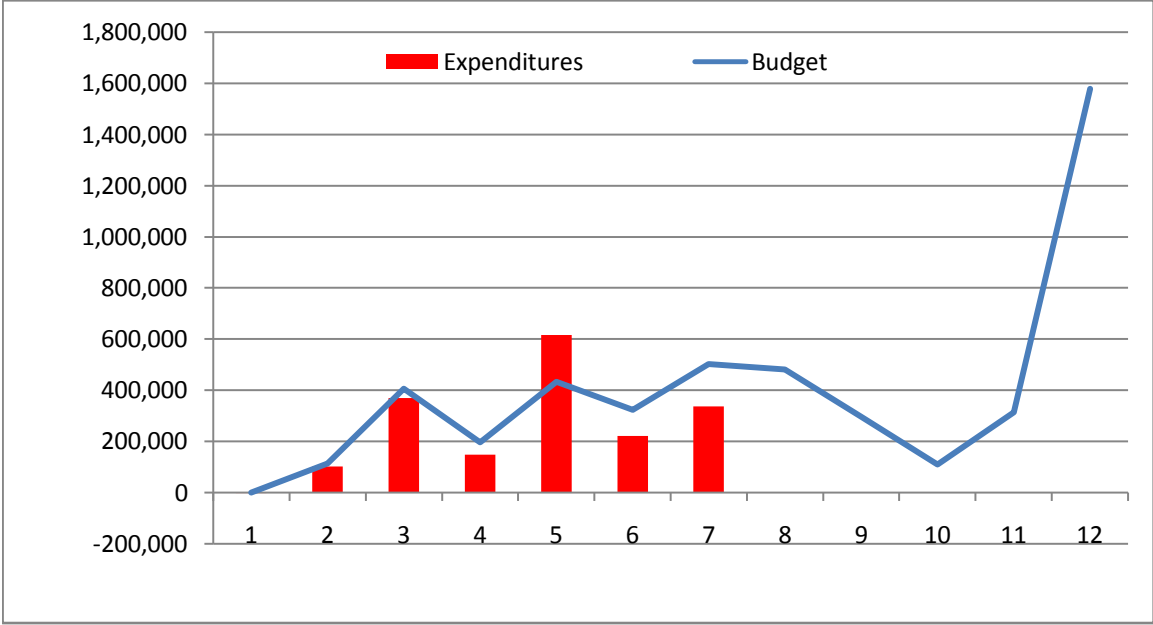
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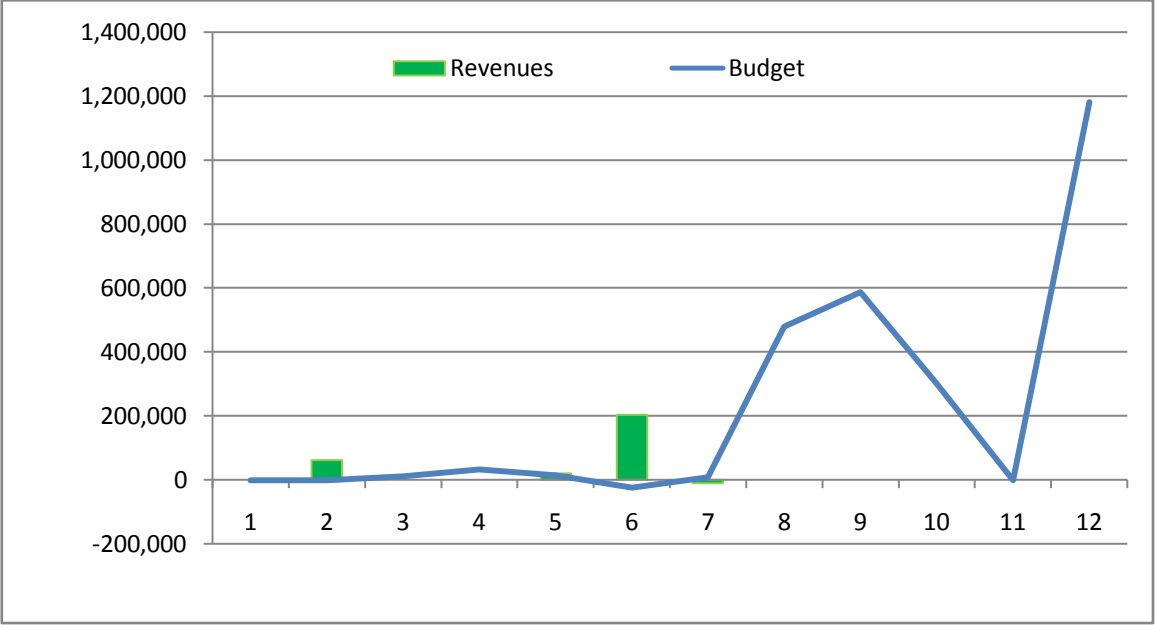
Cumulative Revenues thru July 2013



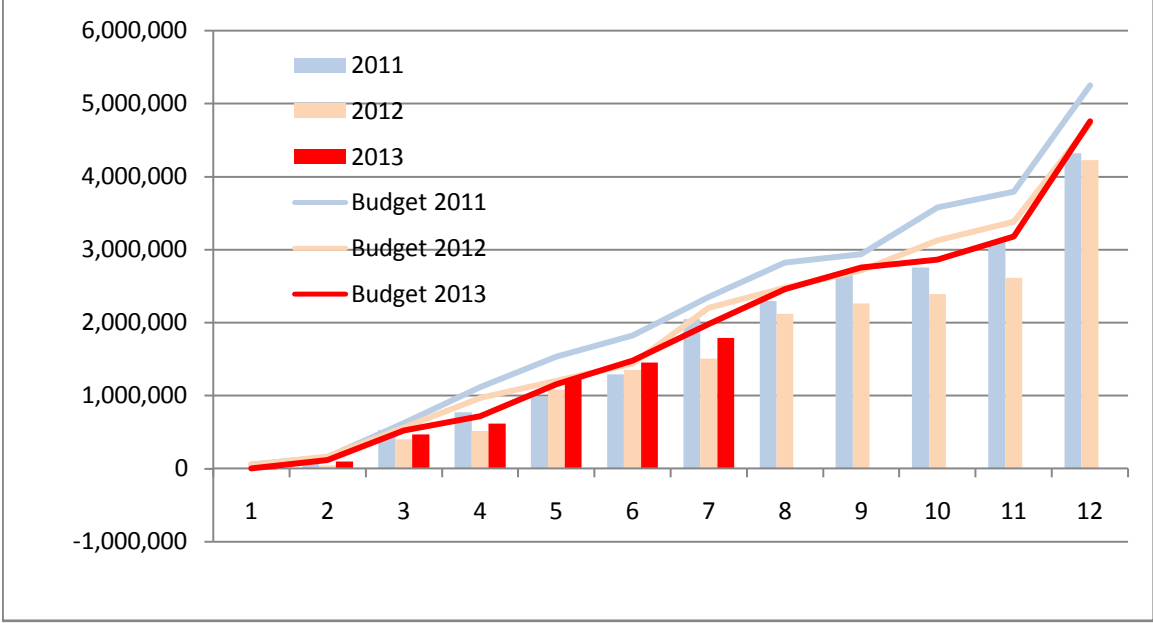
2013 Expenditures by month thru July



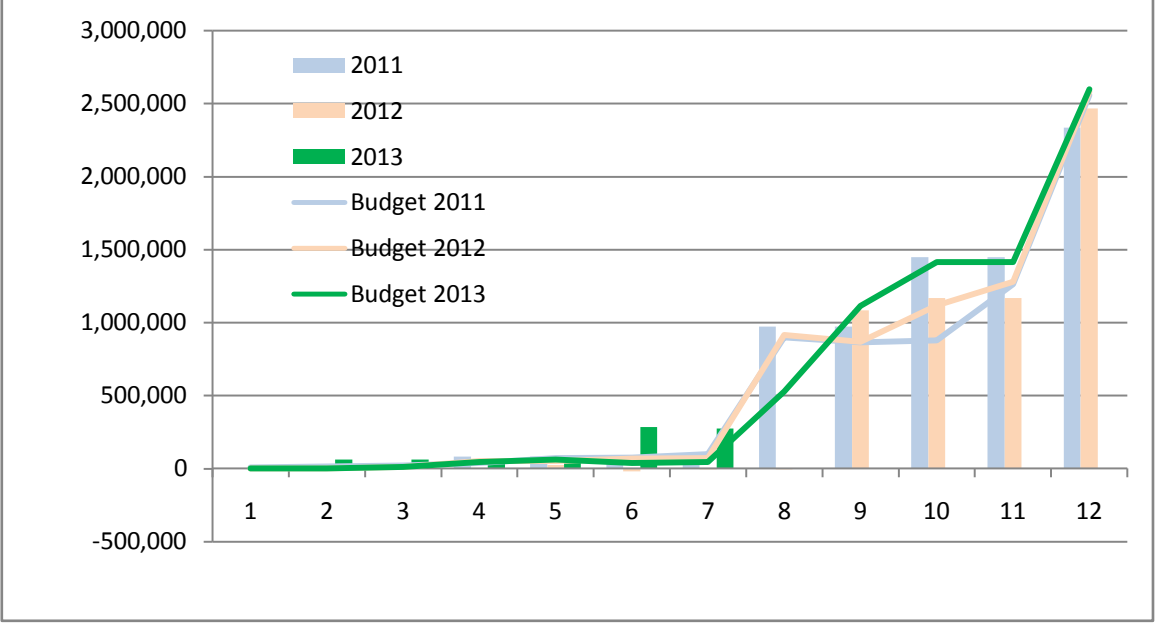
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

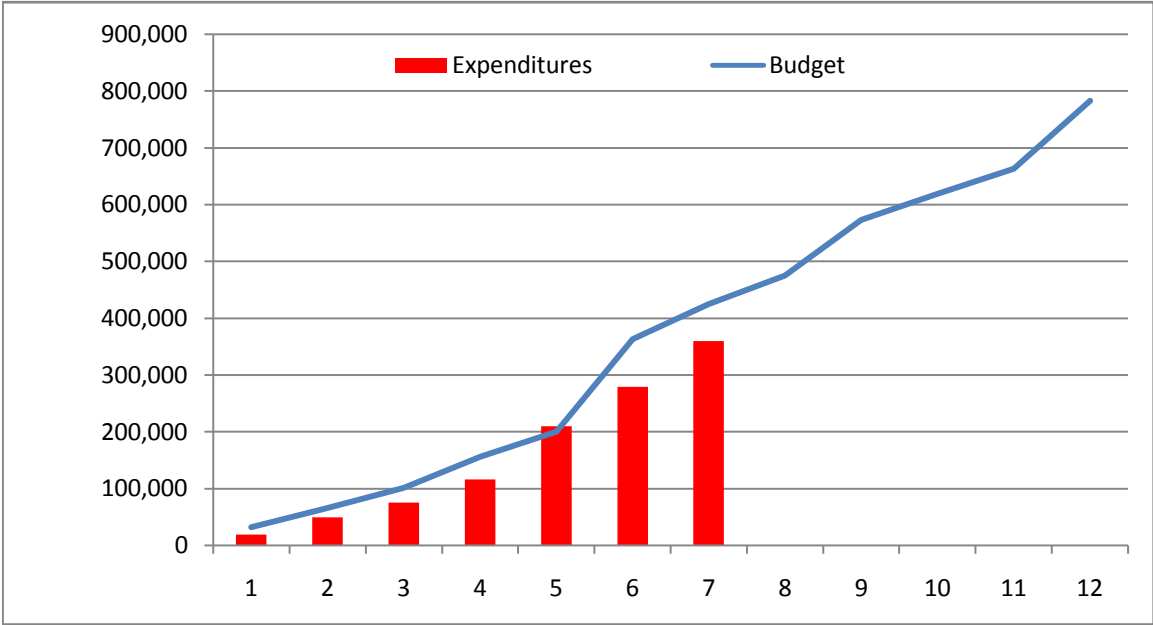


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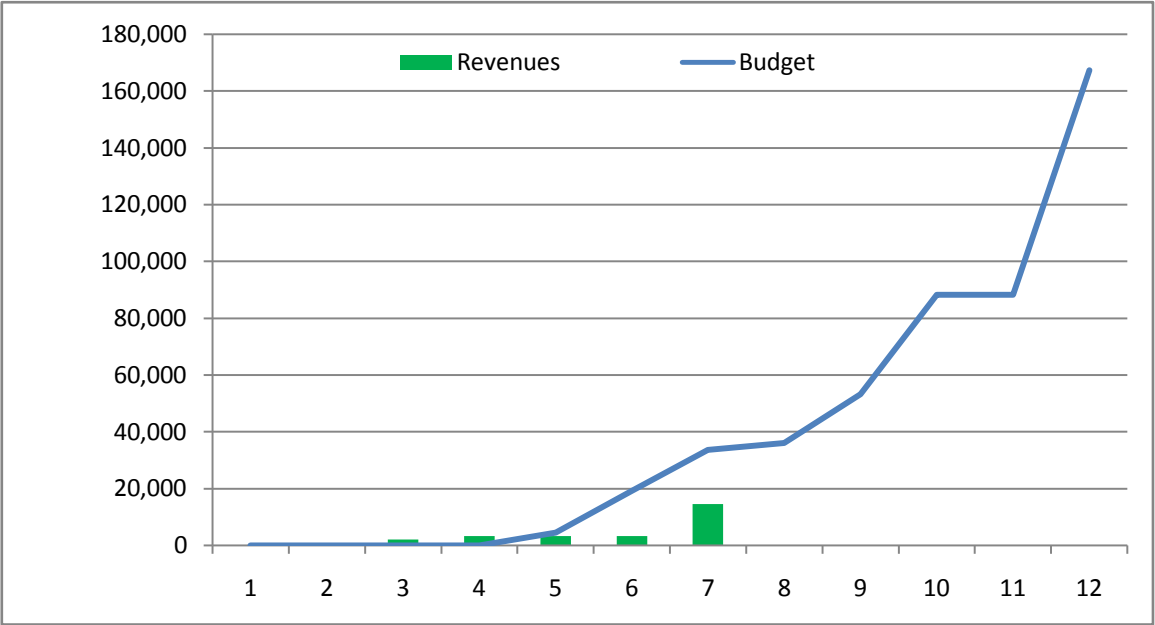
Notes:

Health Department - Planning and Coordination

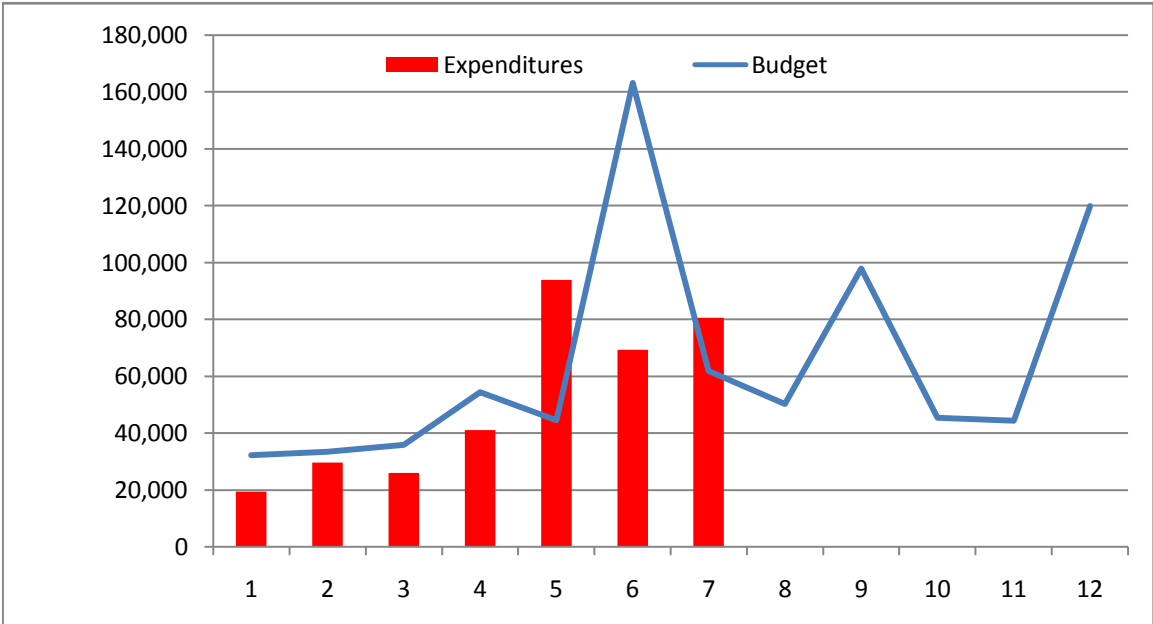
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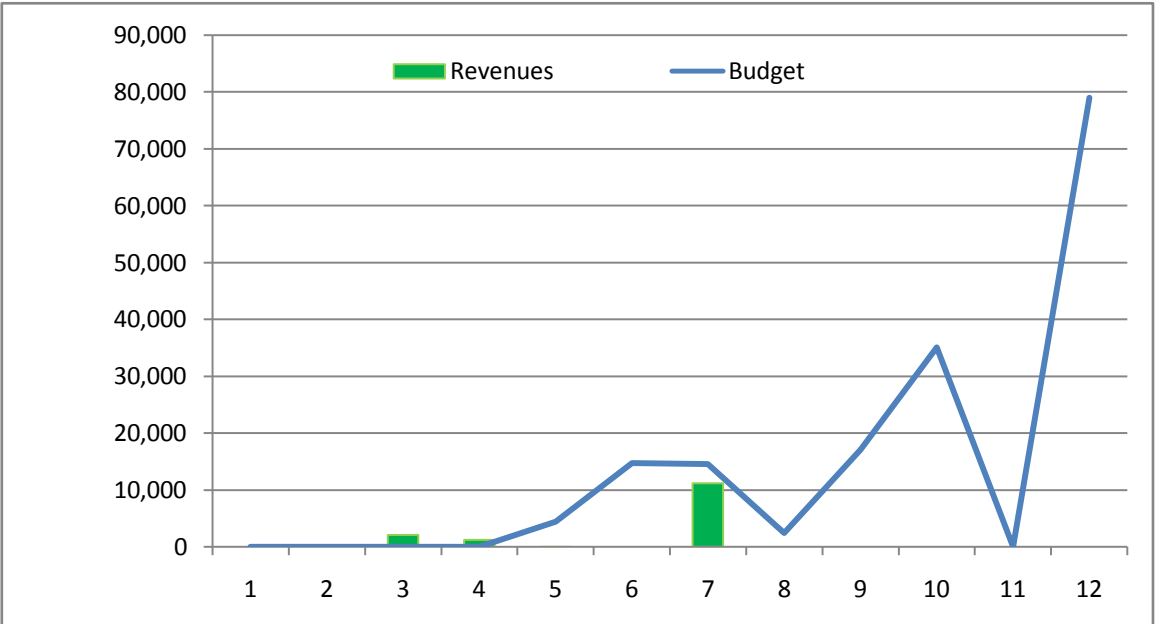
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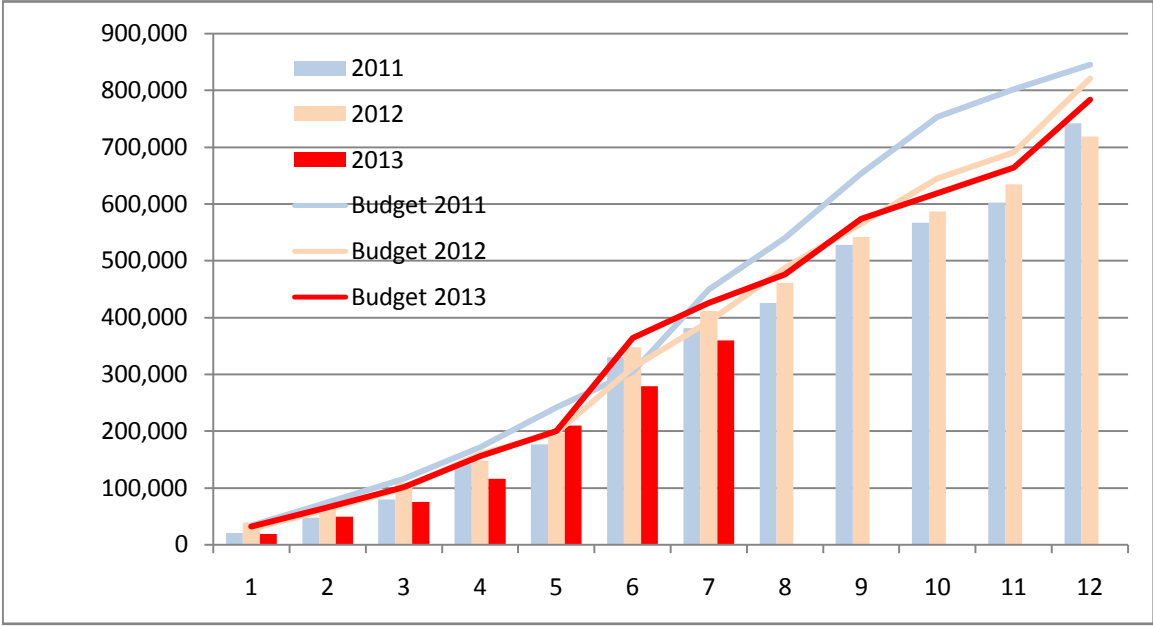
2013 Expenditures by month thru July



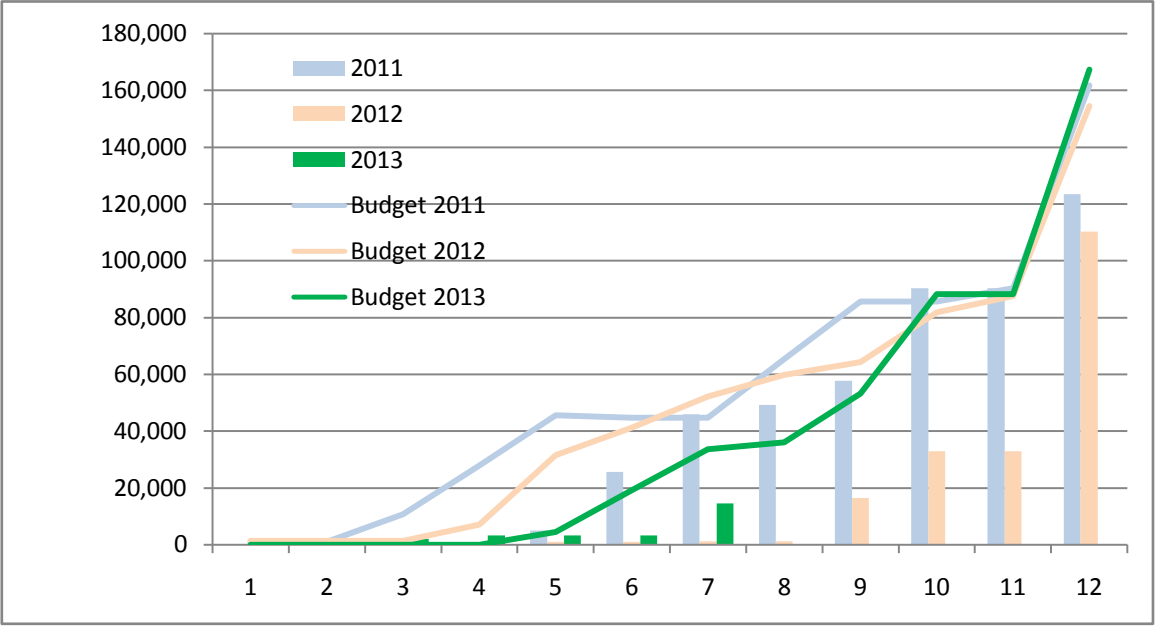
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

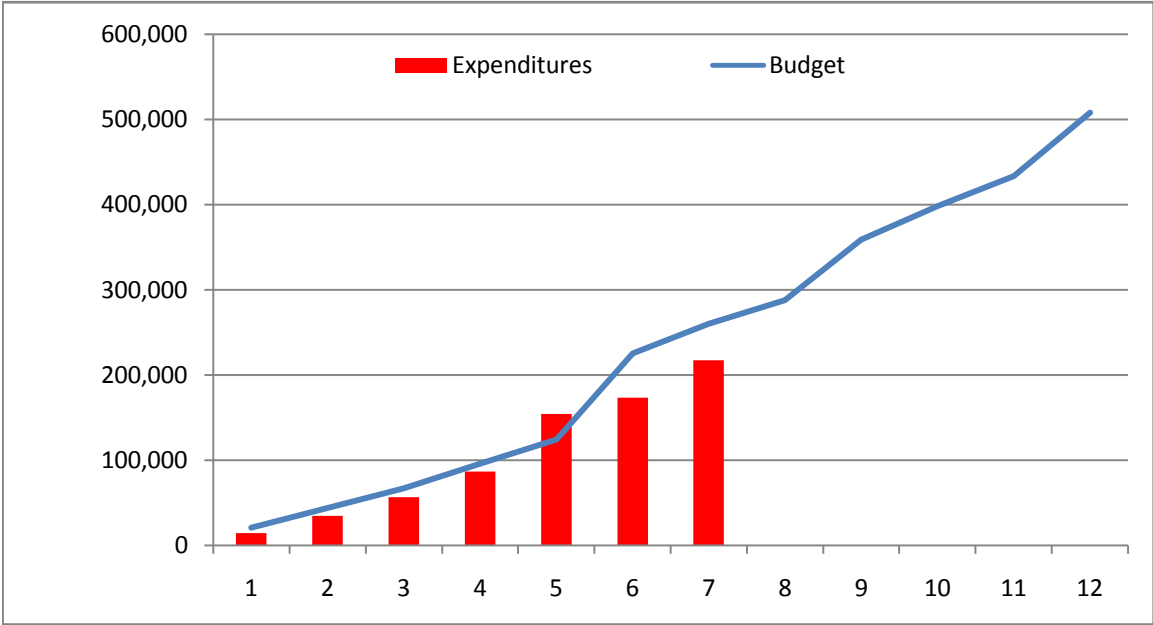


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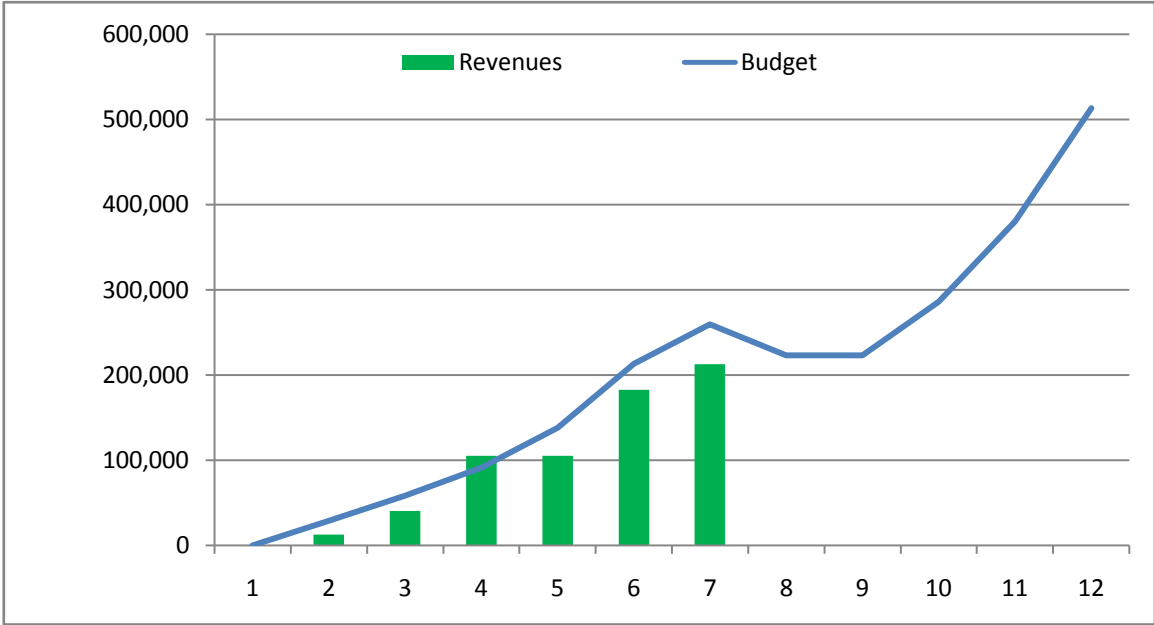
Notes:

Health Department - Women, Infants & Children

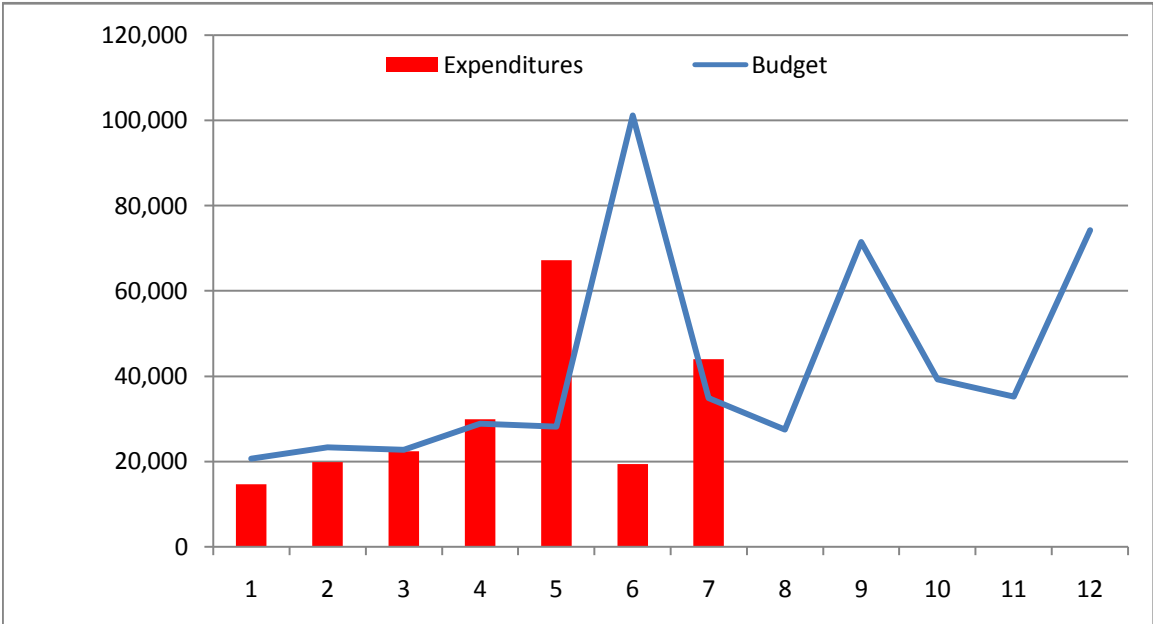
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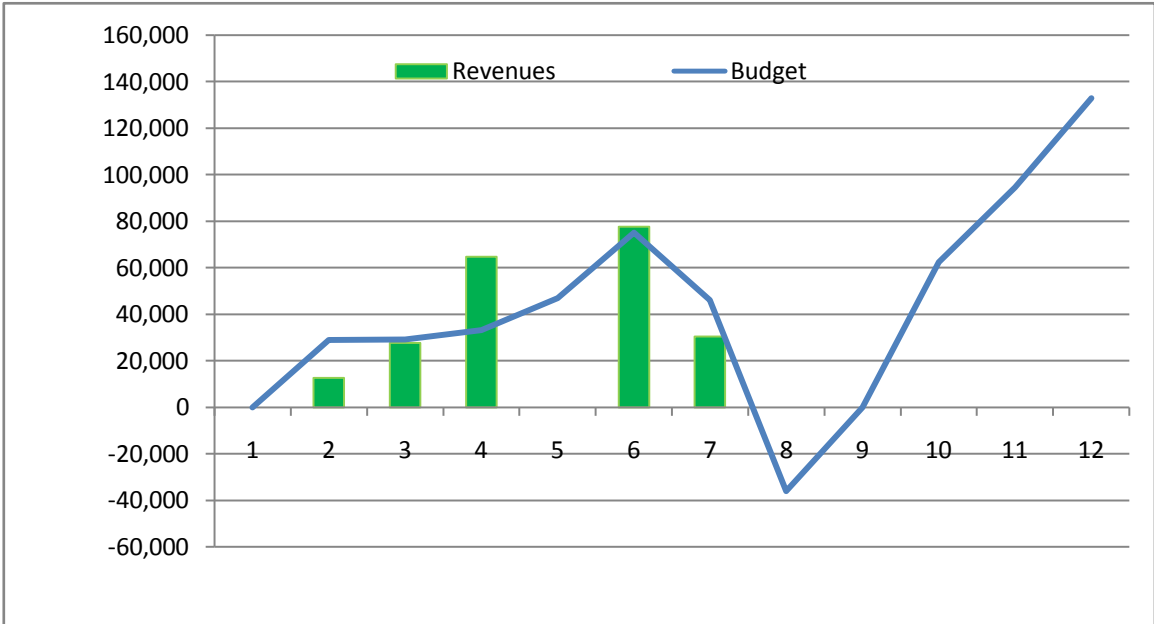
Cumulative Revenues thru July 2013



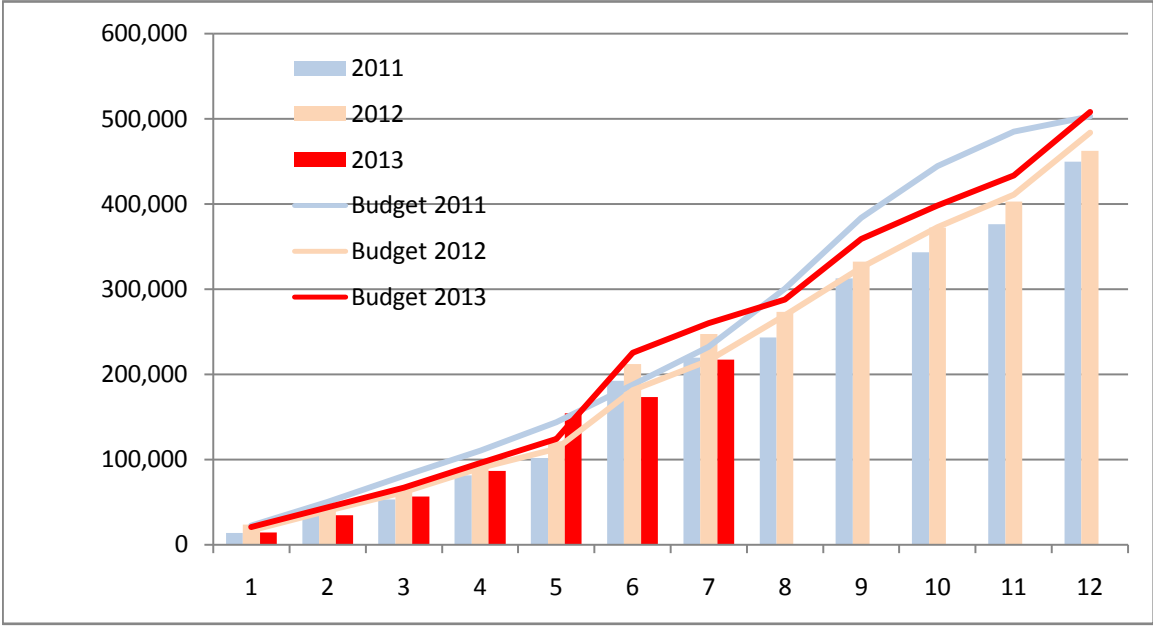
2013 Expenditures by month thru July



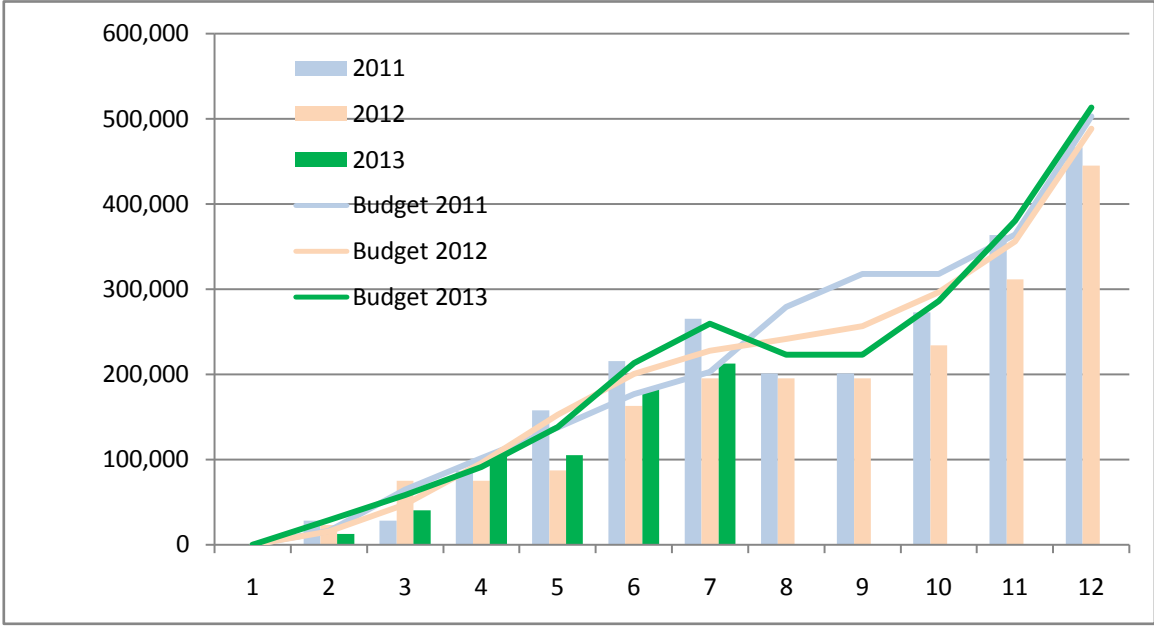
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

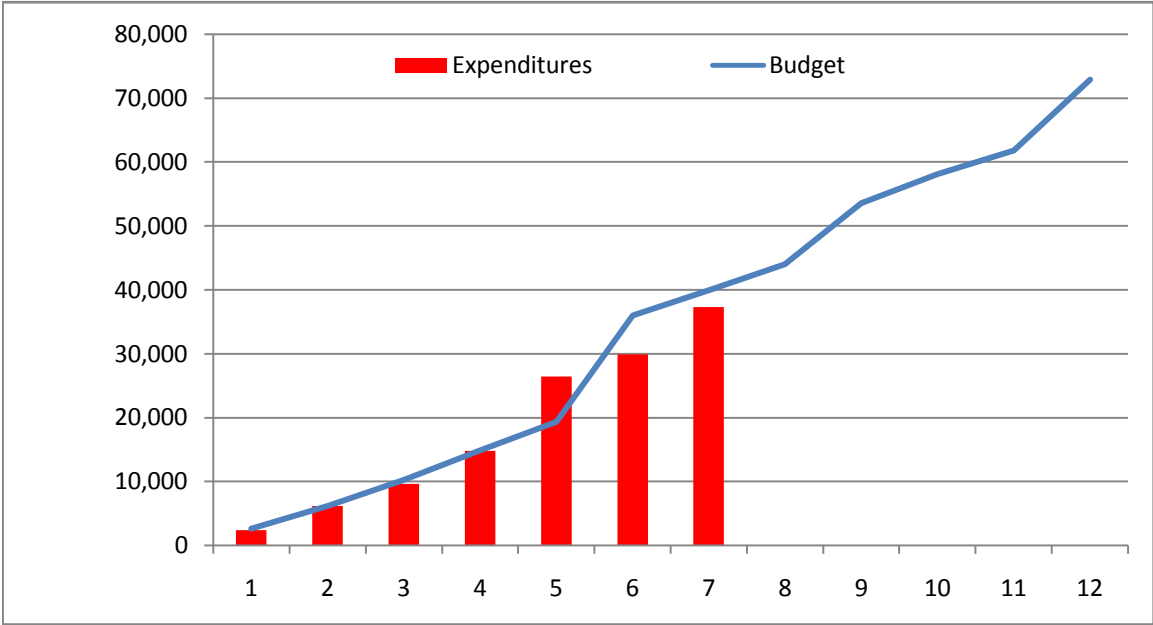


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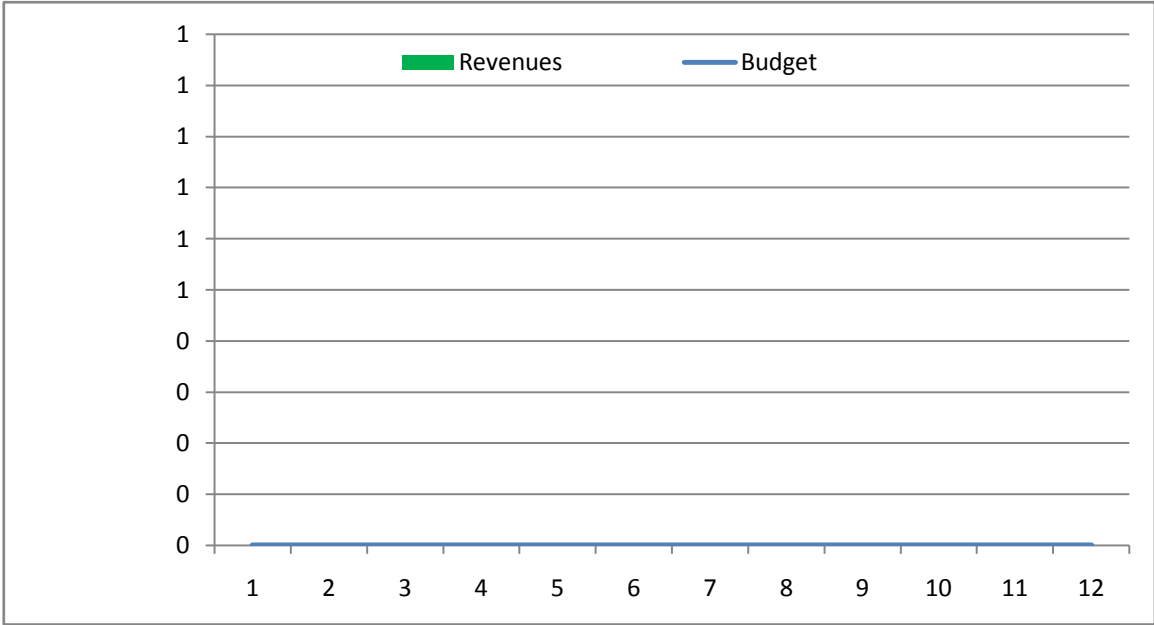
Notes:

Health Department - Occupational Health & Safety

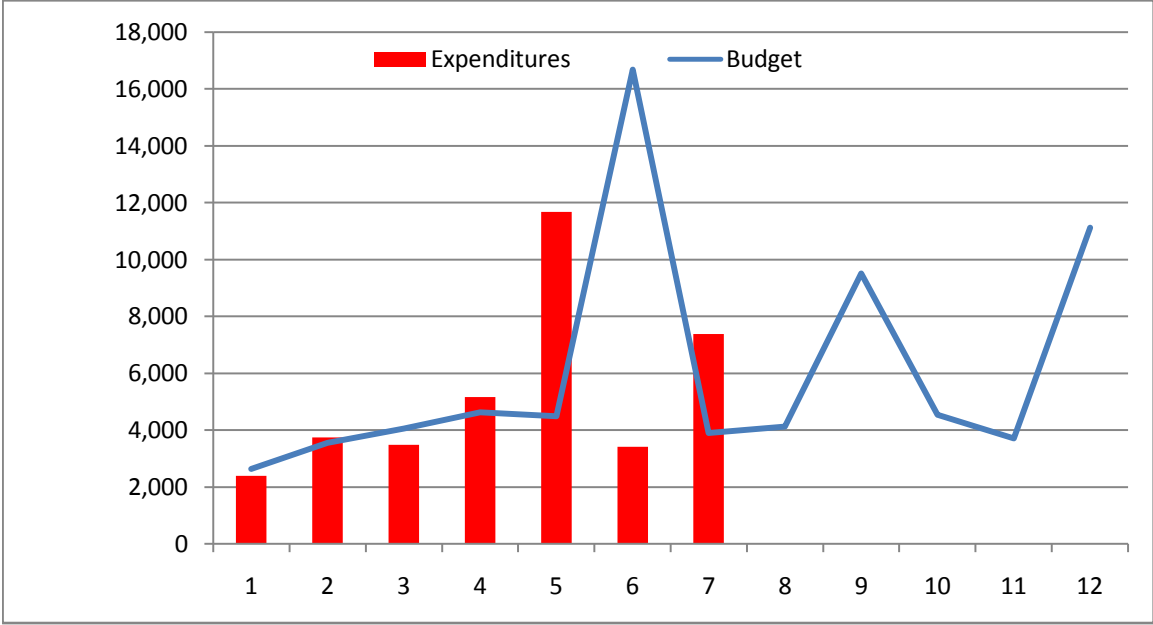
Cumulative Expenditures thru July 2013



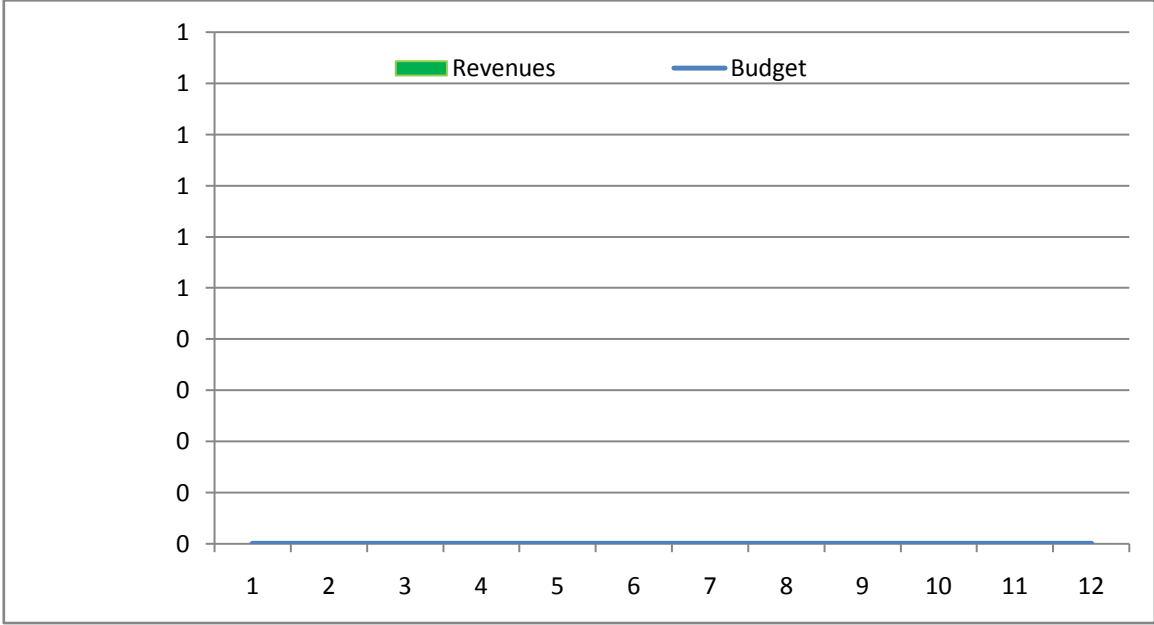
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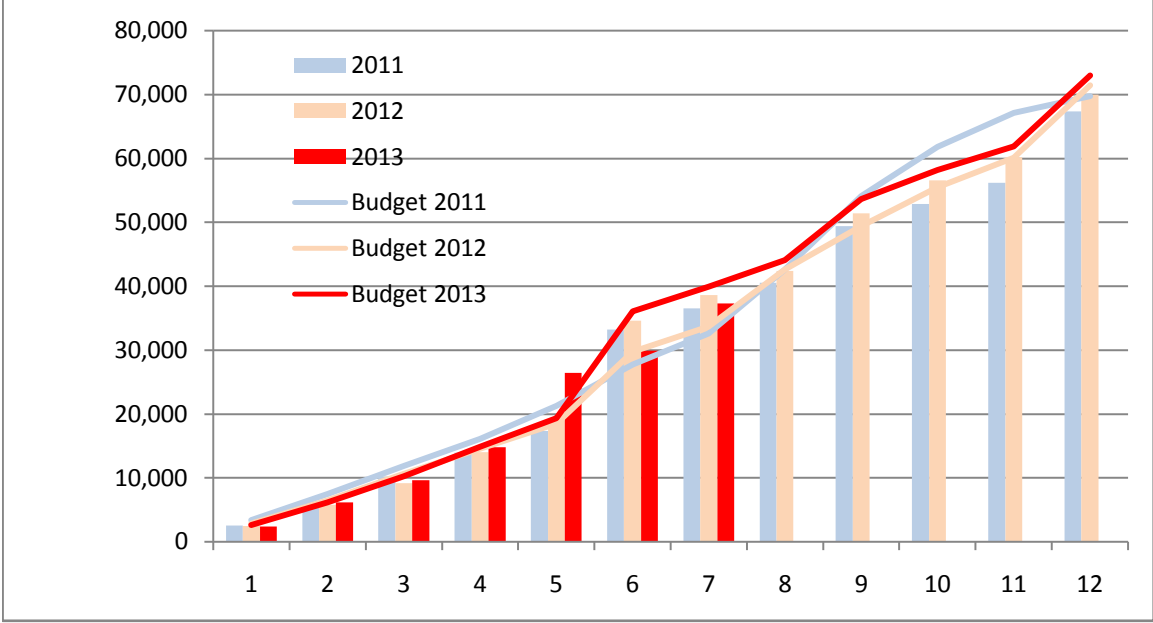
2013 Expenditures by month thru July



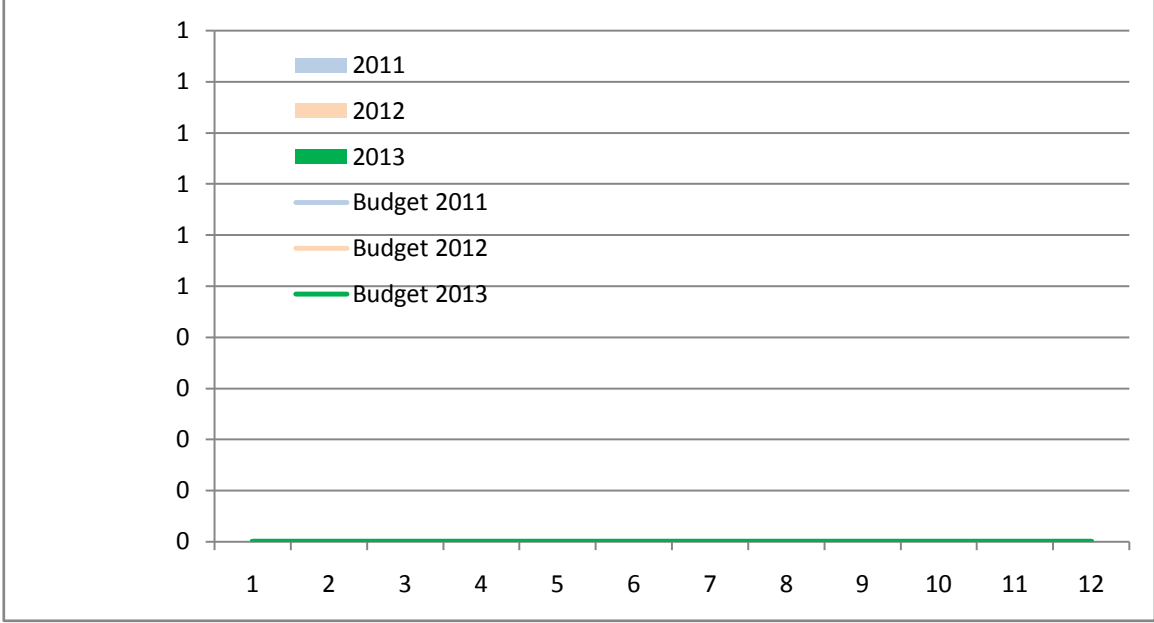
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

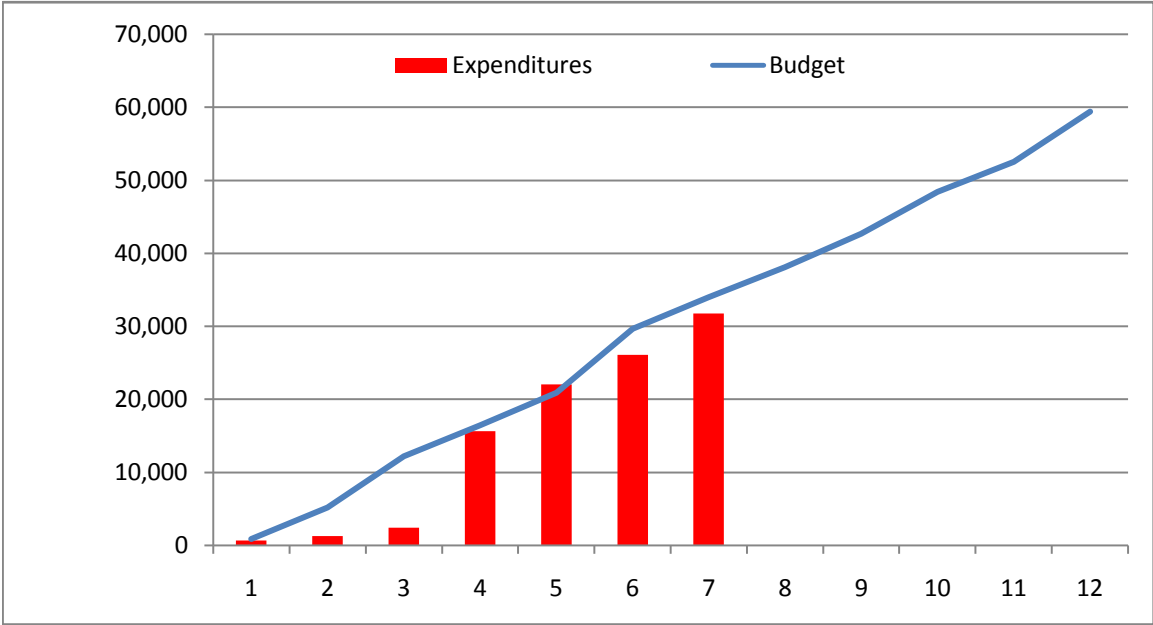


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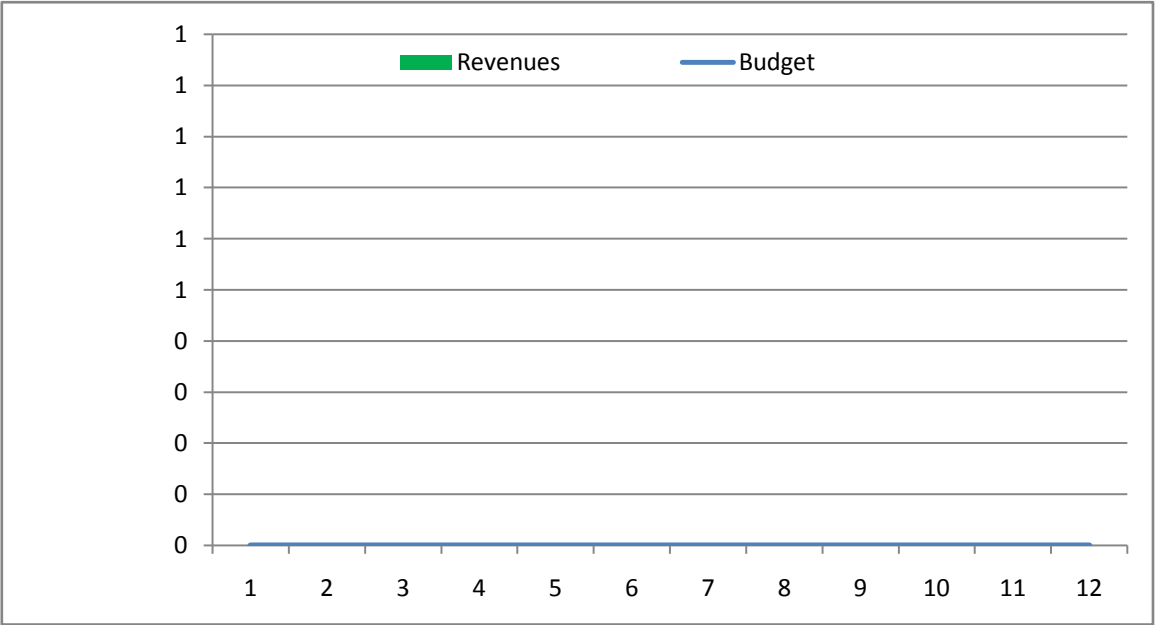
Notes:

Health Department - Medical Examiner

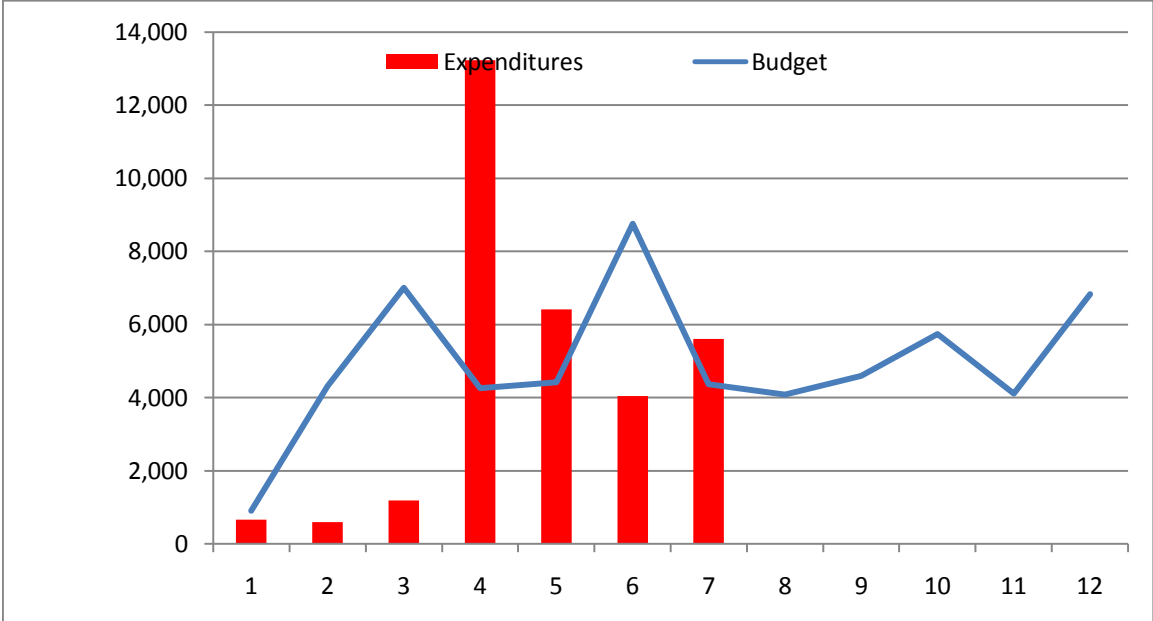
Cumulative Expenditures thru July 2013



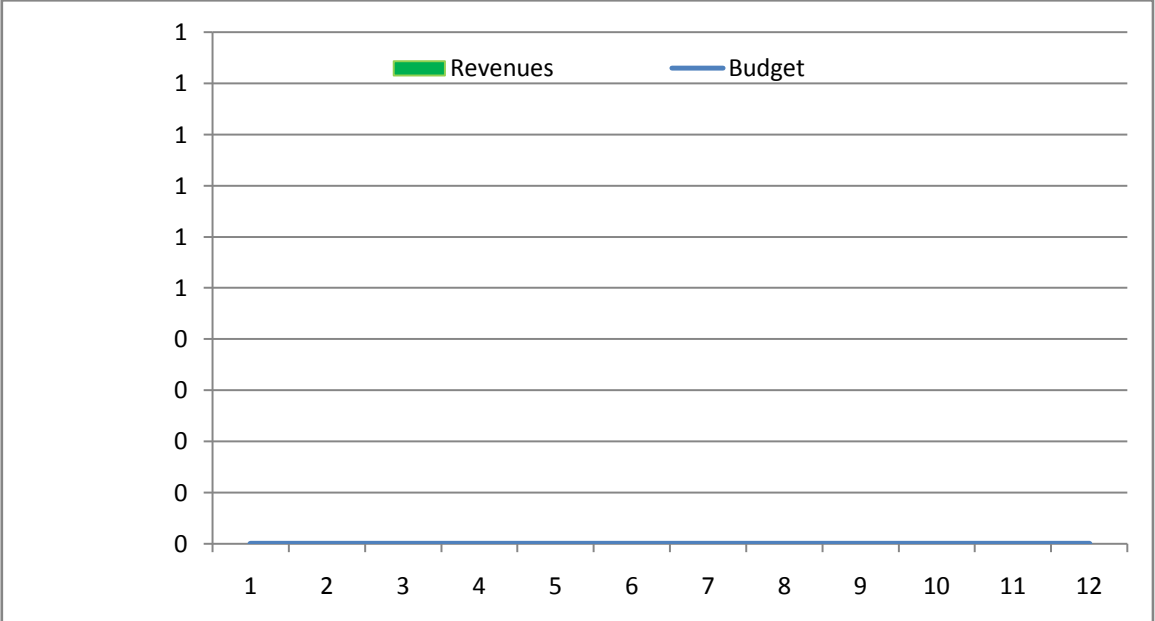
Cumulative Revenues thru July 2013



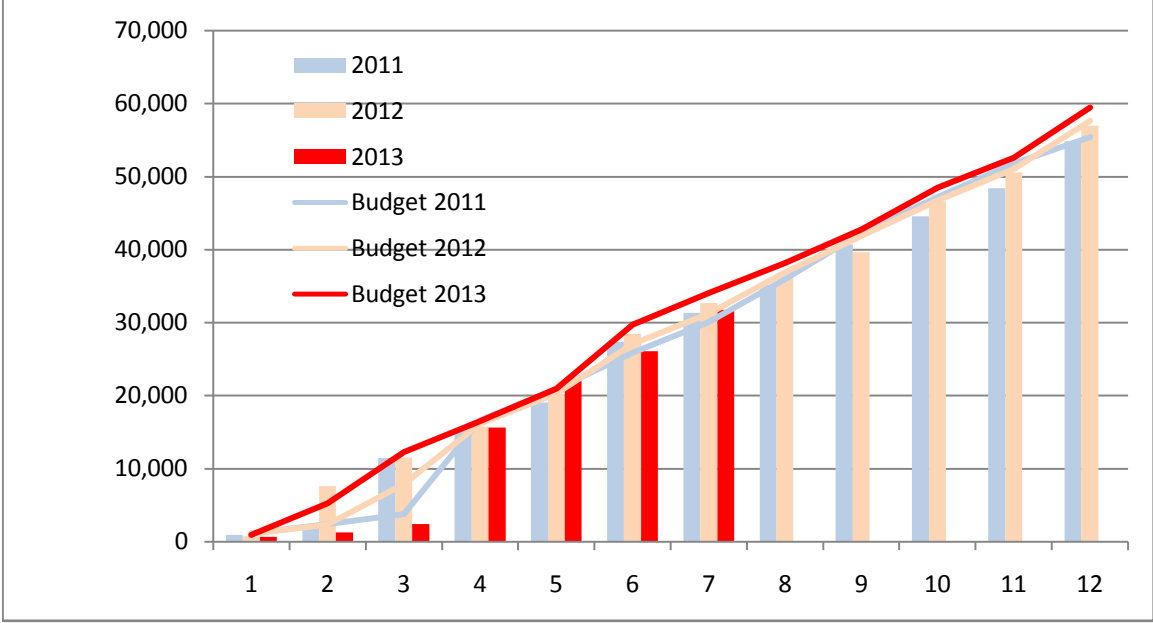
2013 Expenditures by month thru July



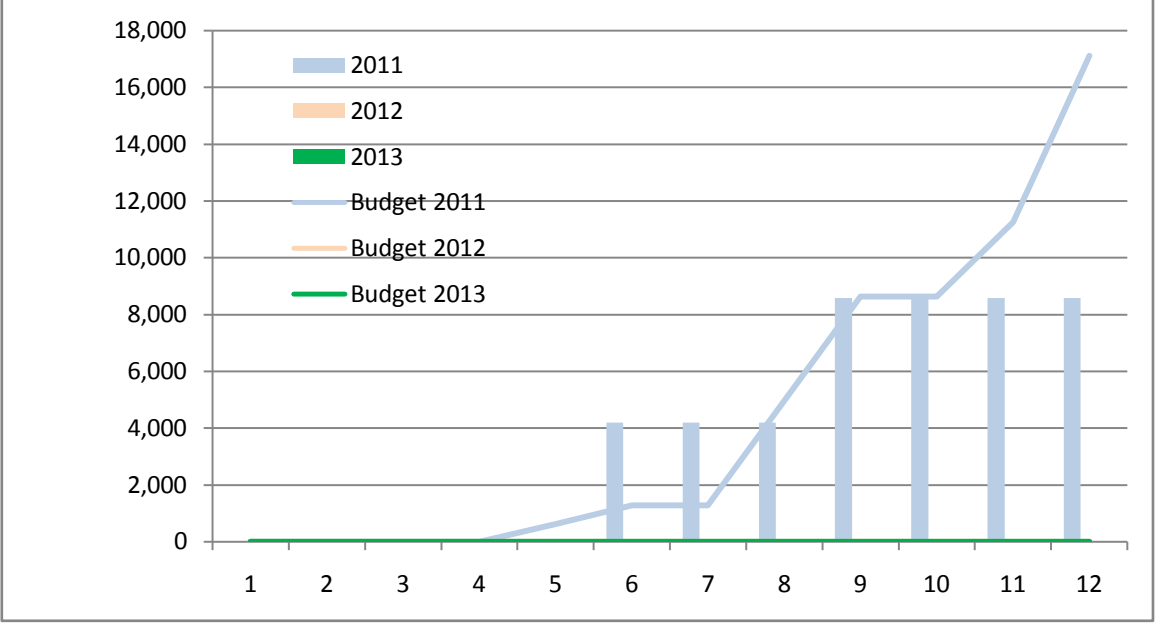
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

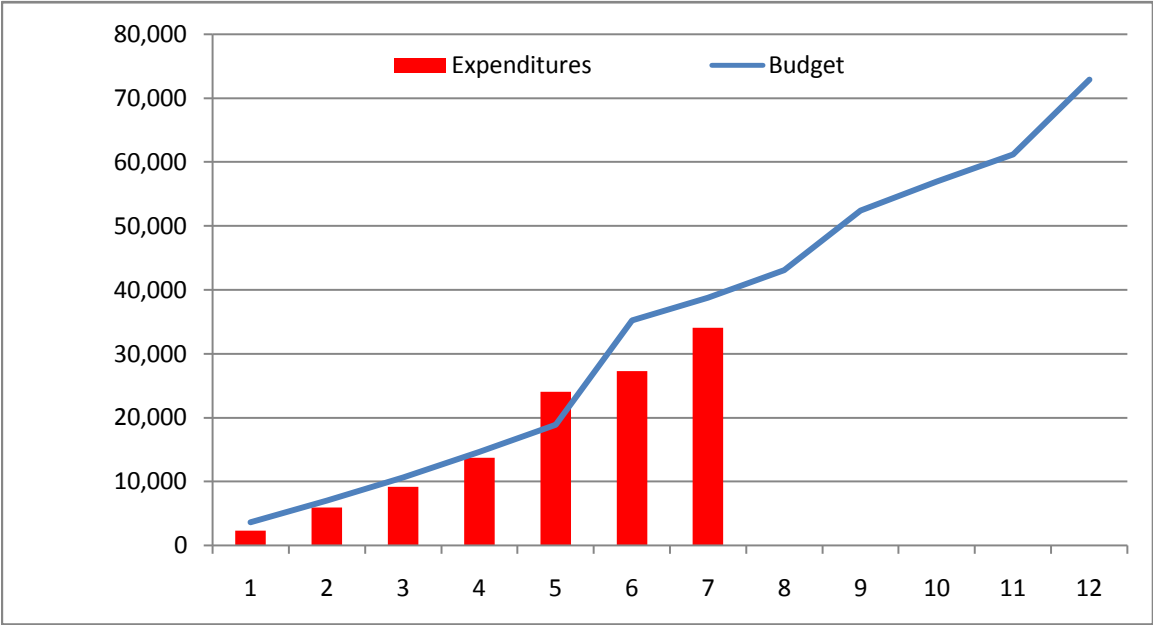


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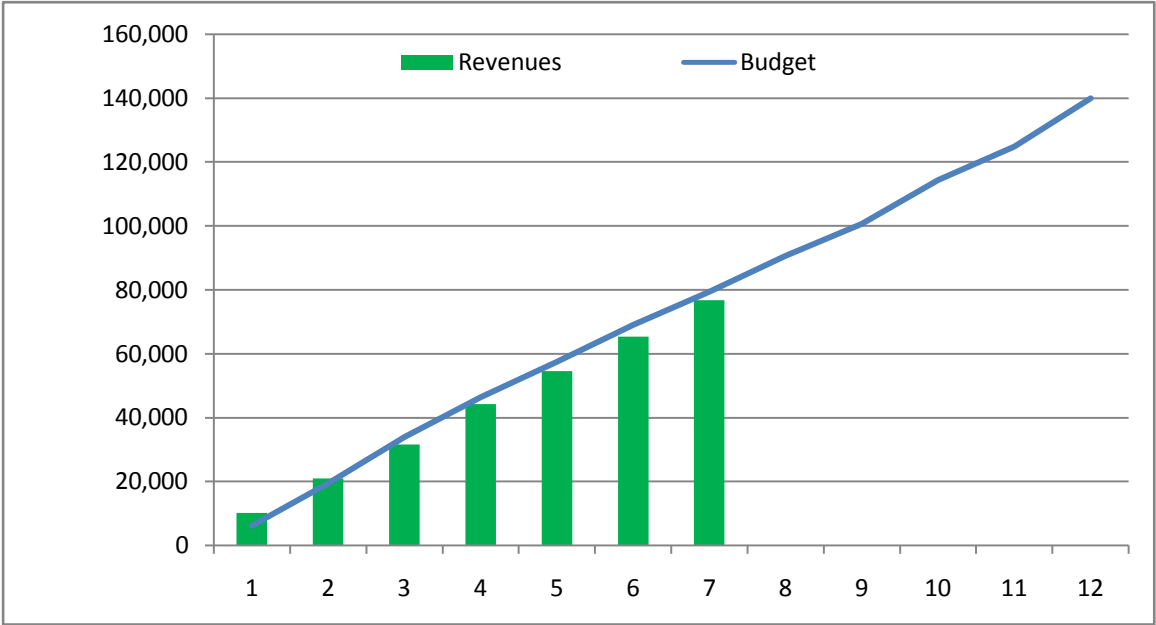
Notes:

Health Department - Vital Records

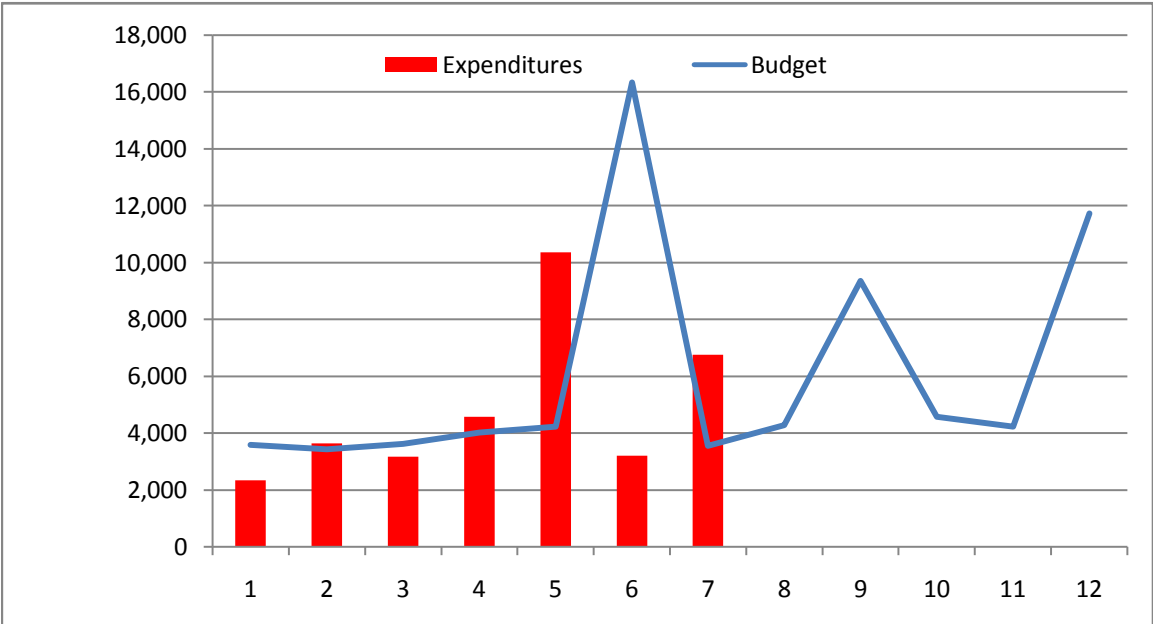
Cumulative Expenditures thru July 2013



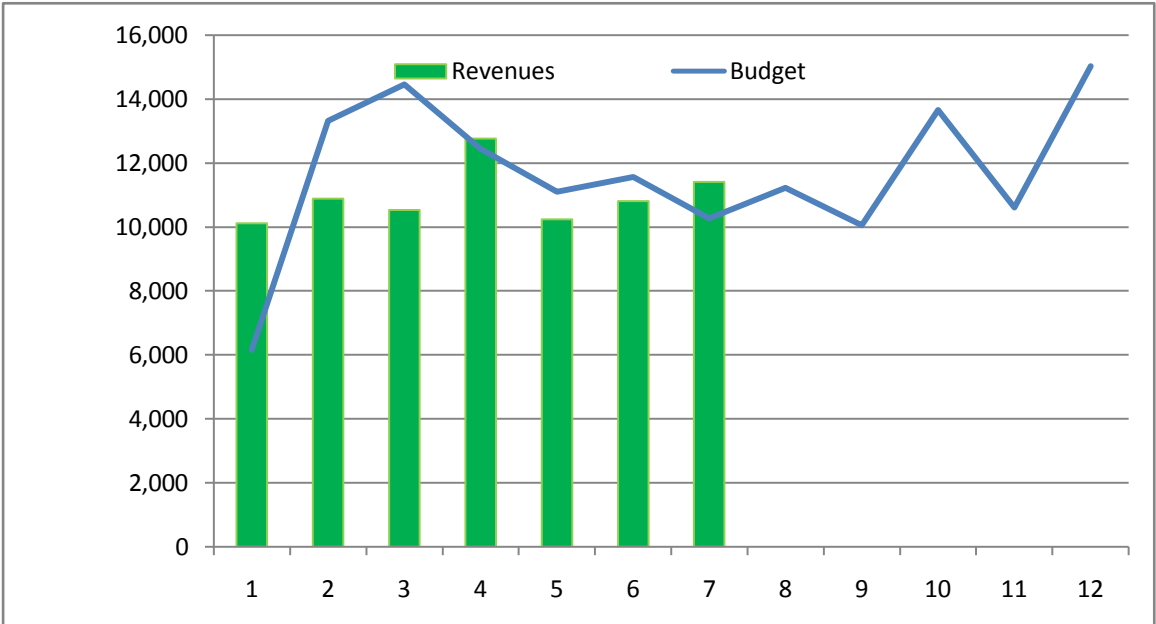
Cumulative Revenues thru July 2013



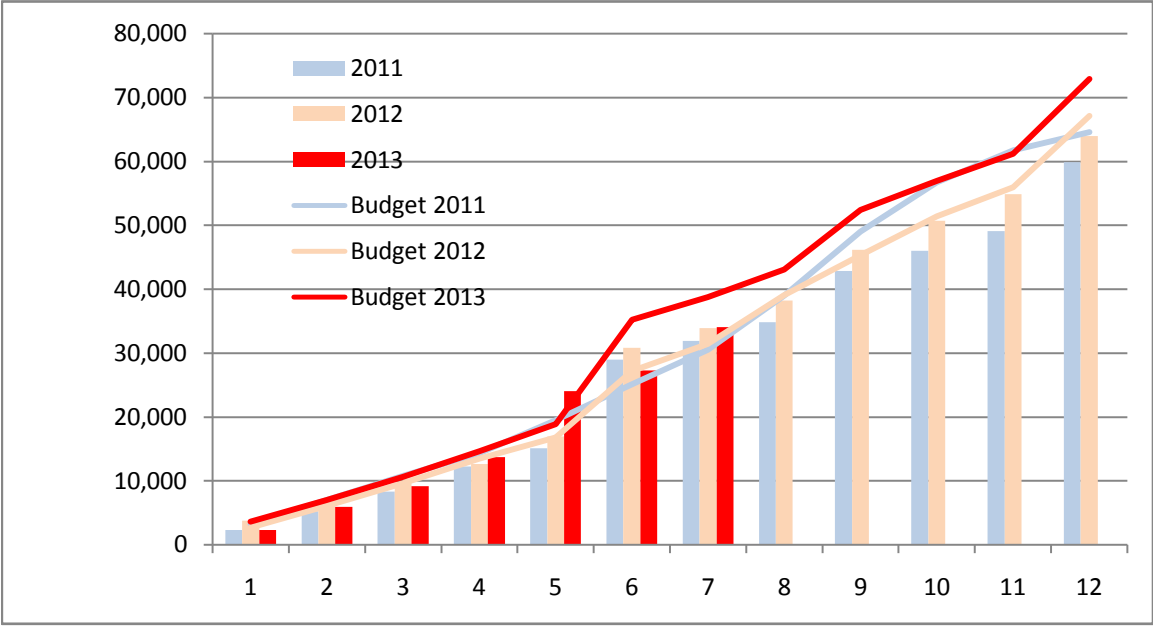
2013 Expenditures by month thru July



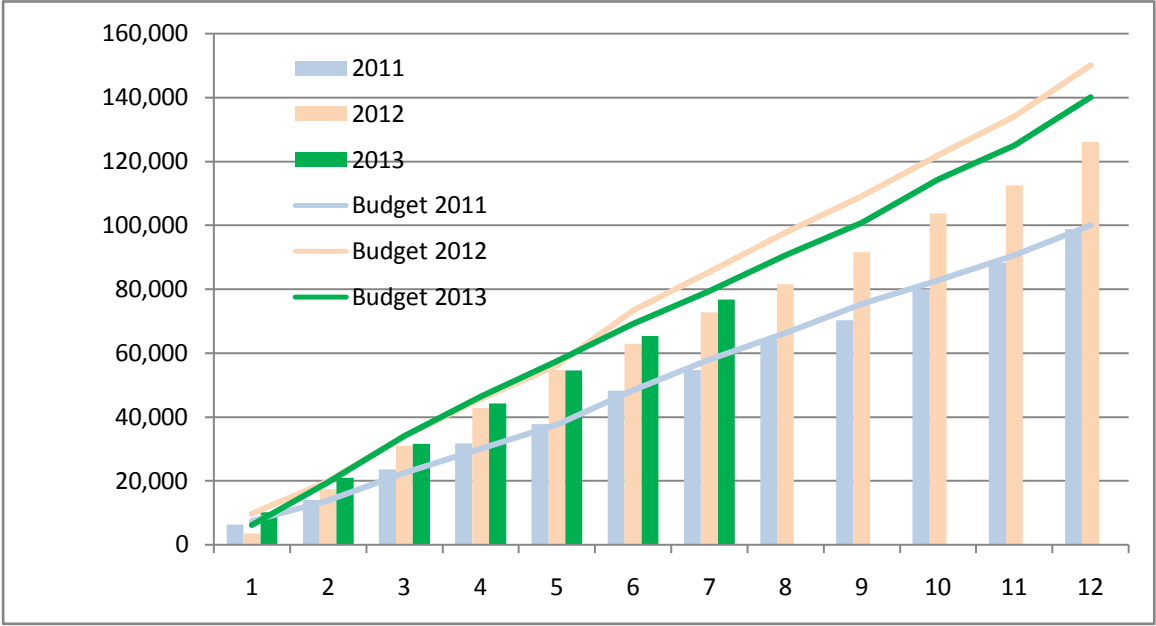
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

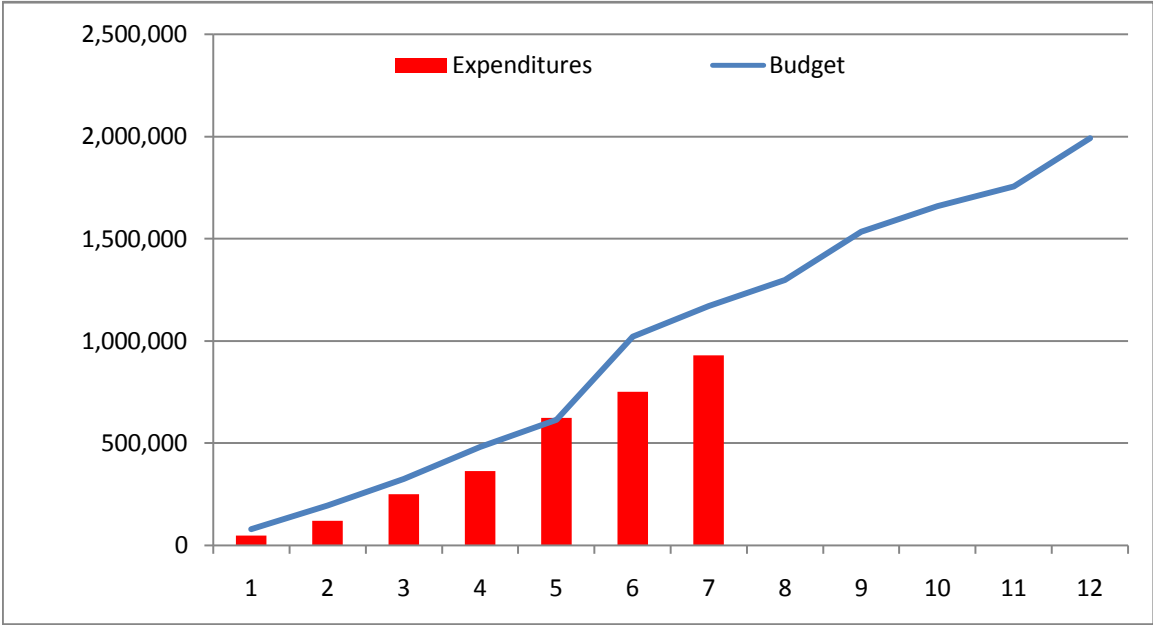


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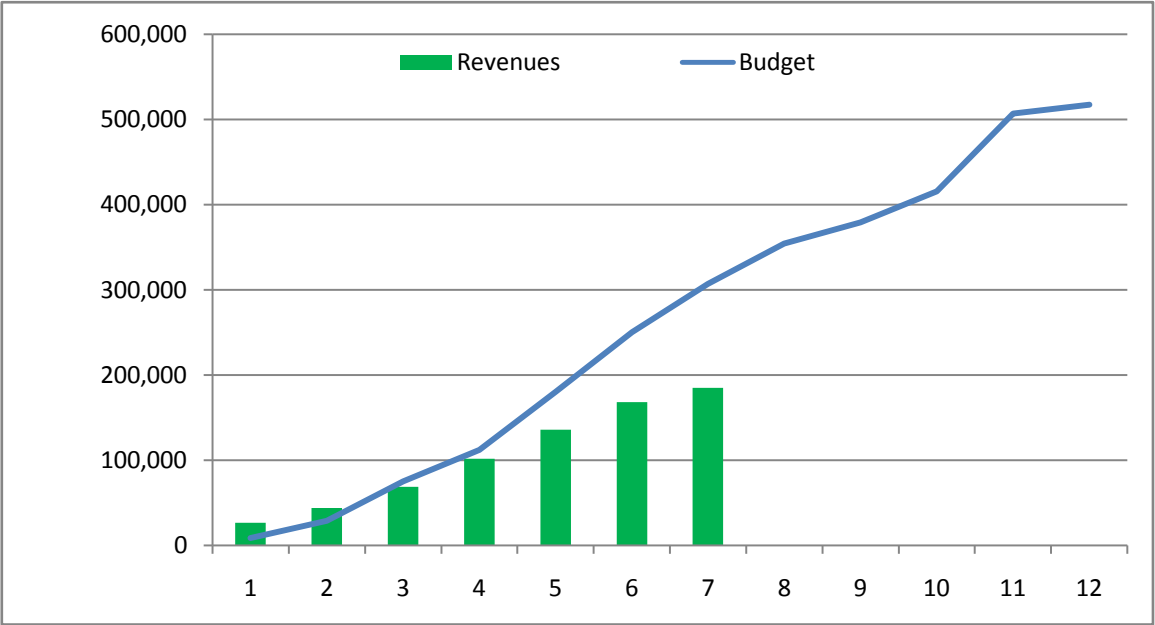
Notes:

Health Department - Division For Community Health

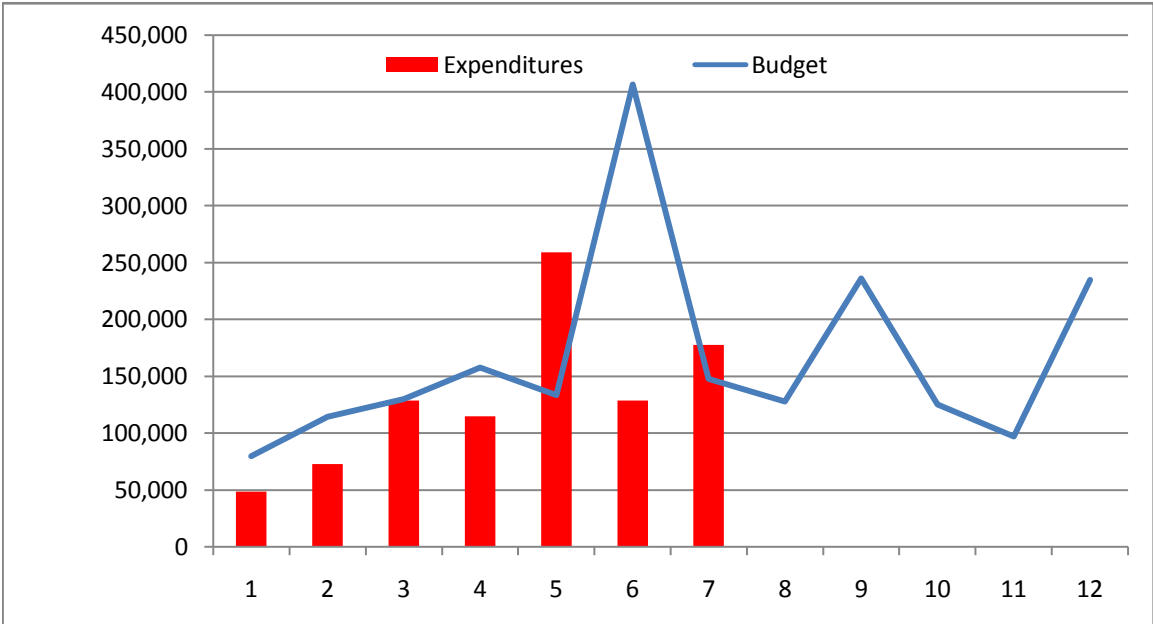
Cumulative Expenditures thru July 2013



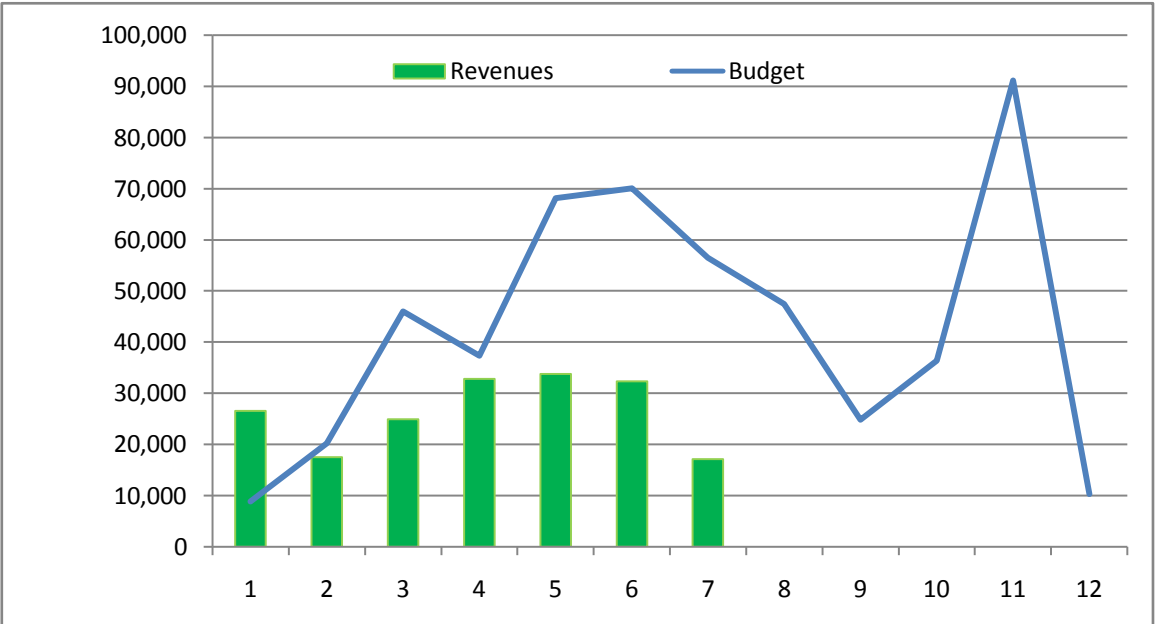
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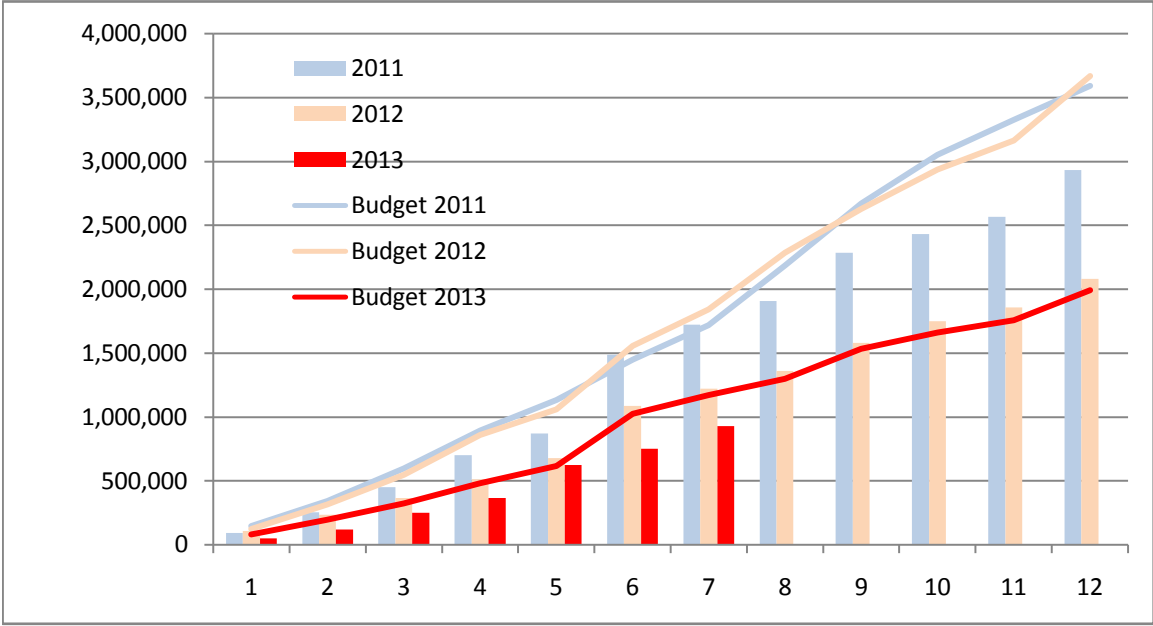
2013 Expenditures by month thru July



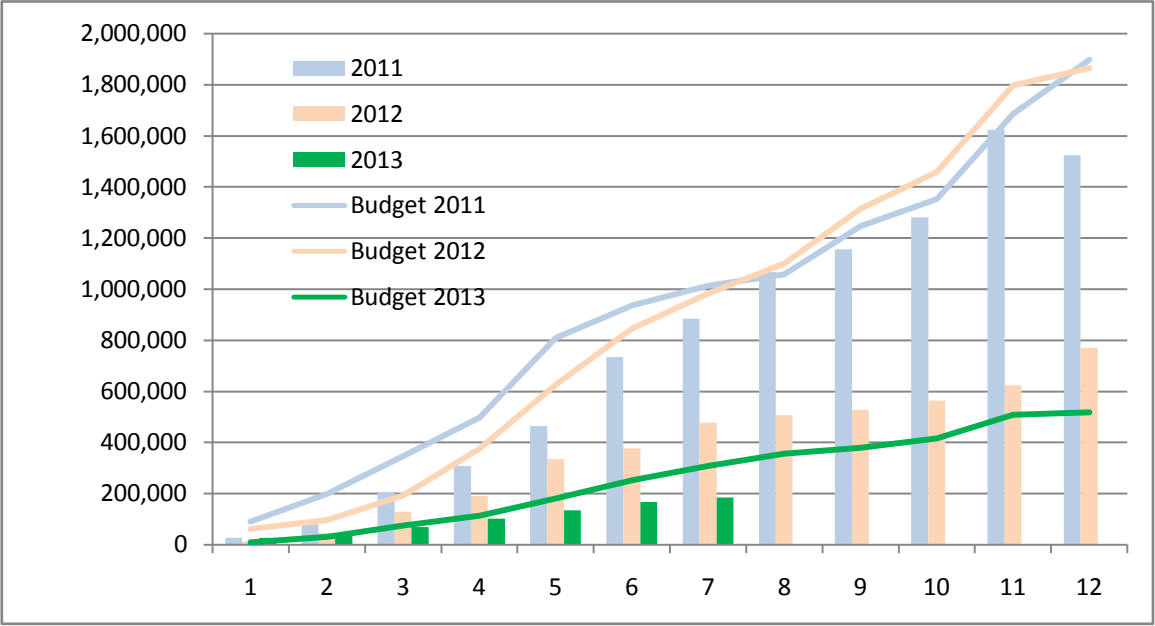
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

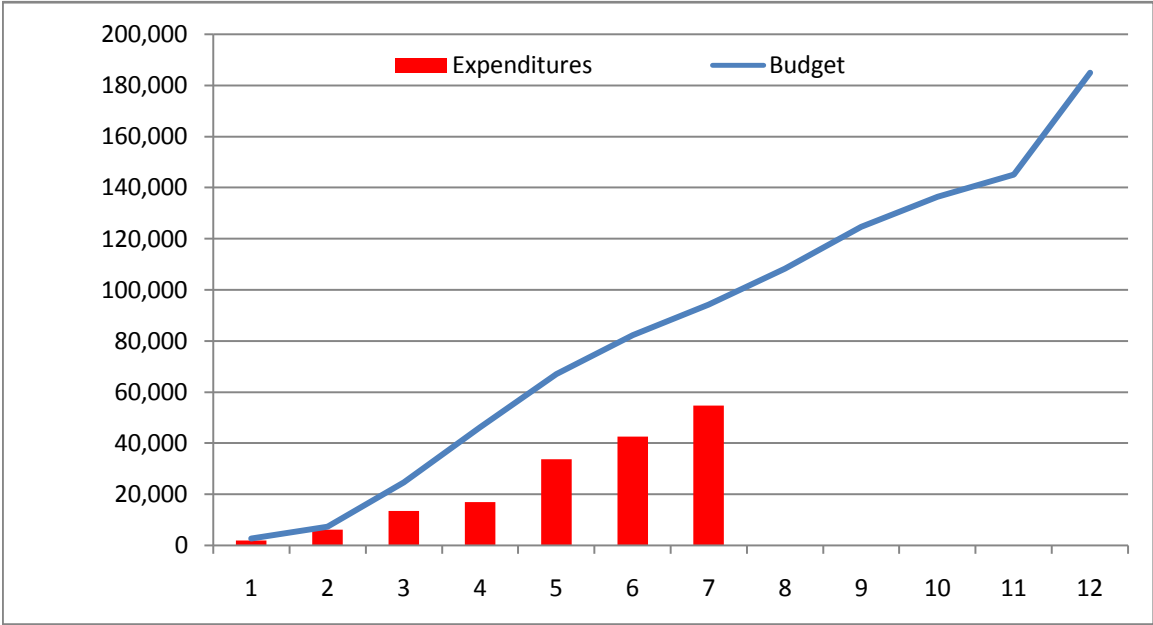


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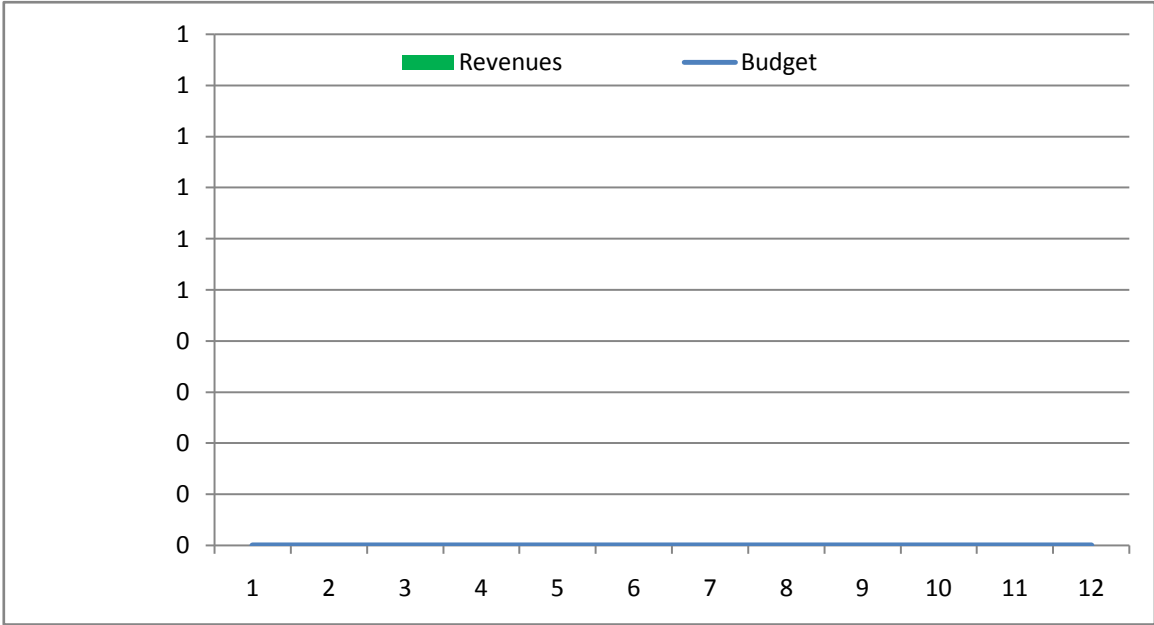
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Health Department - Medical Examiner Program

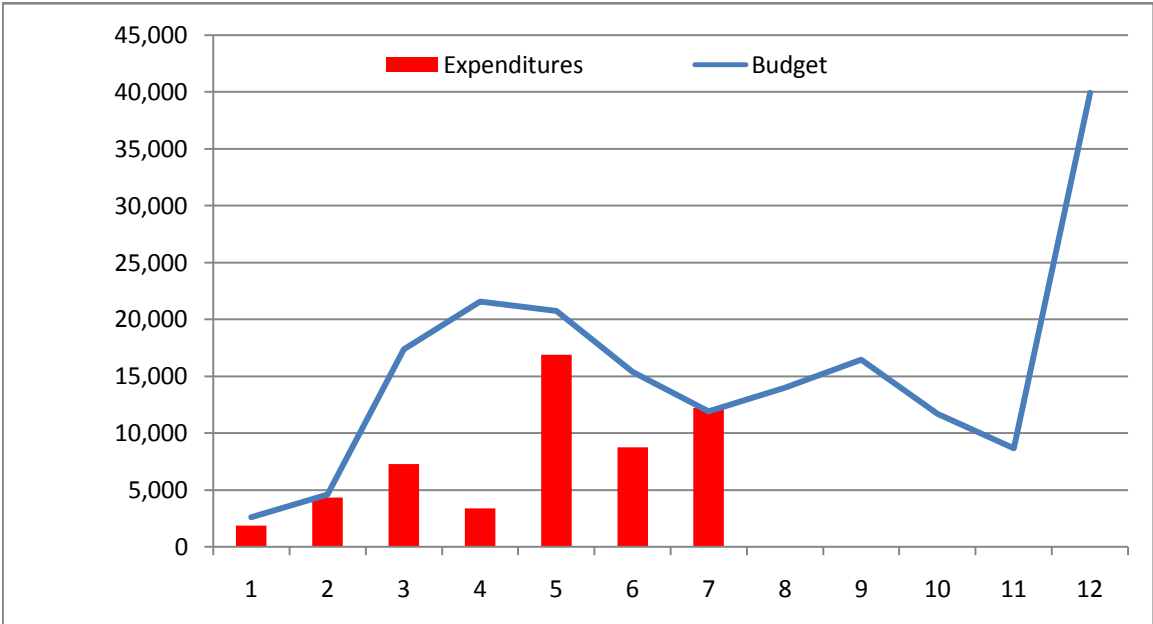
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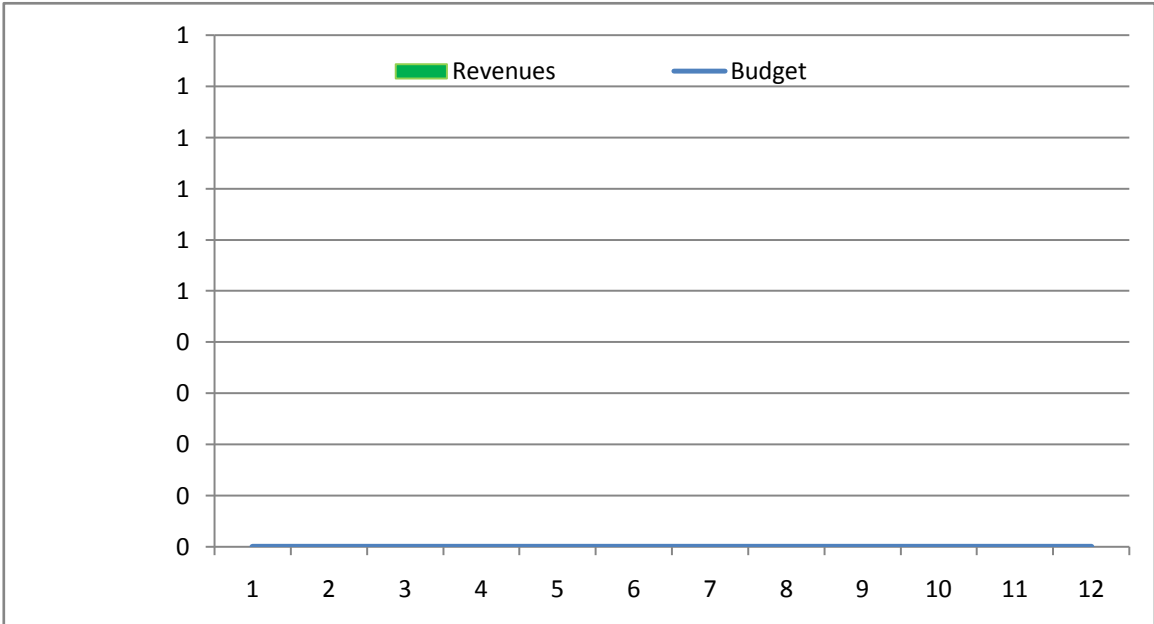
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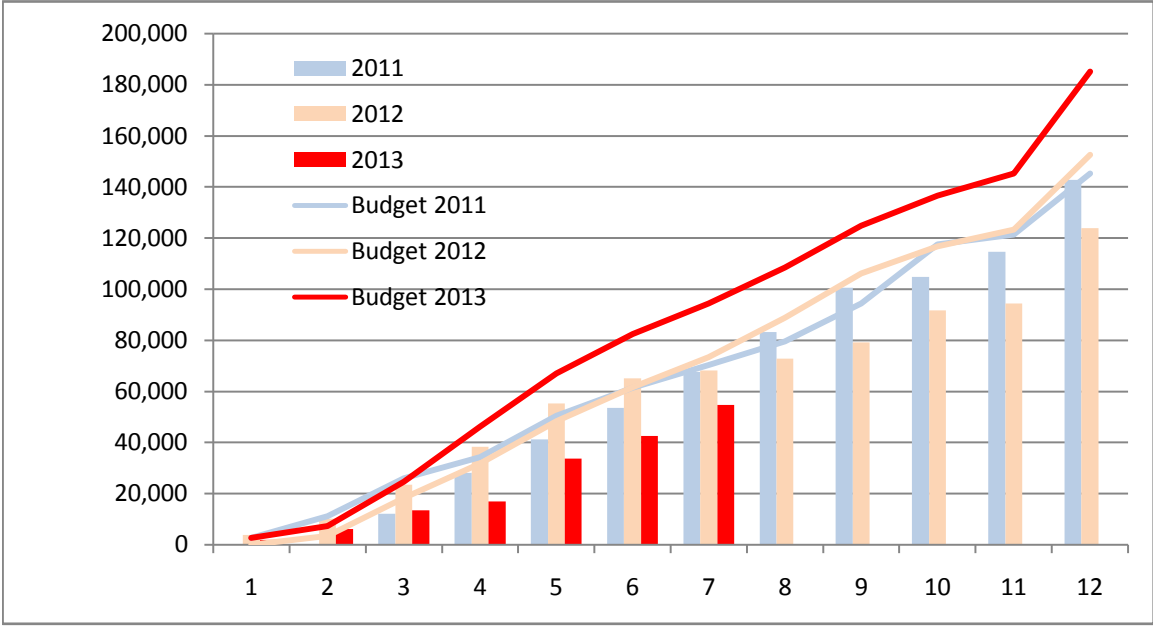
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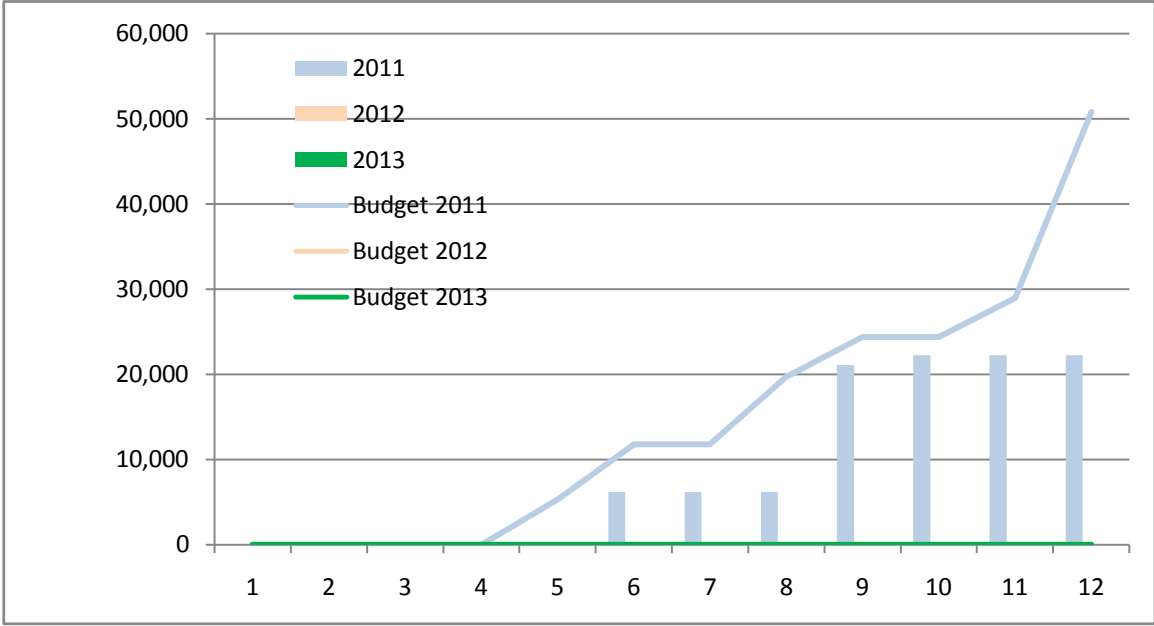
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

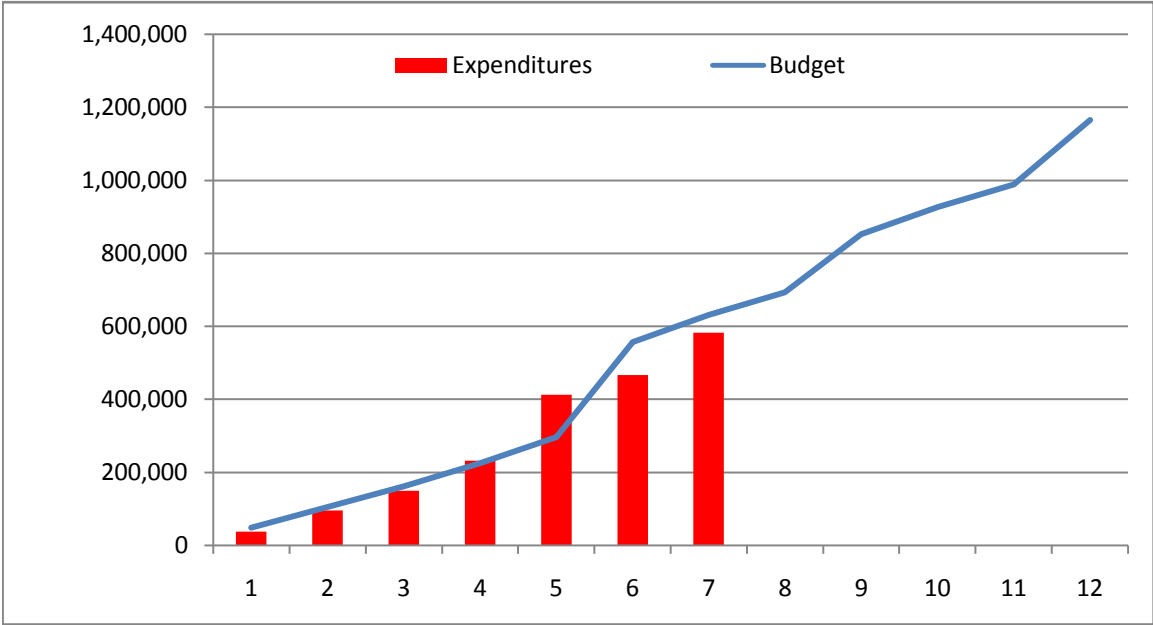


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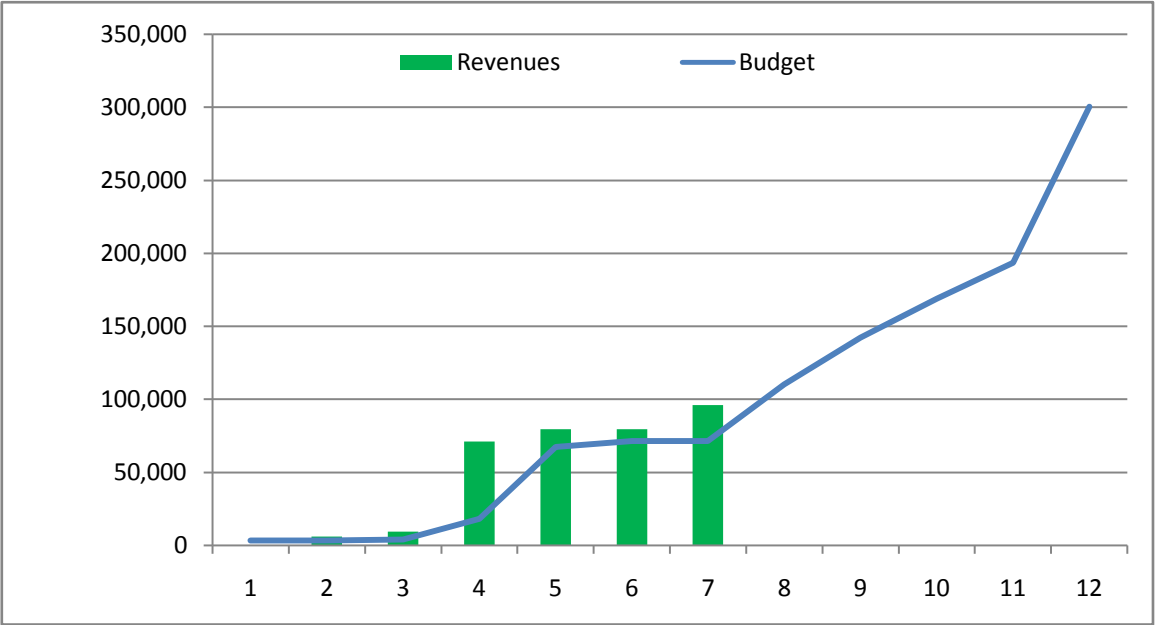
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Health Department - Planning and Coordination of CSN

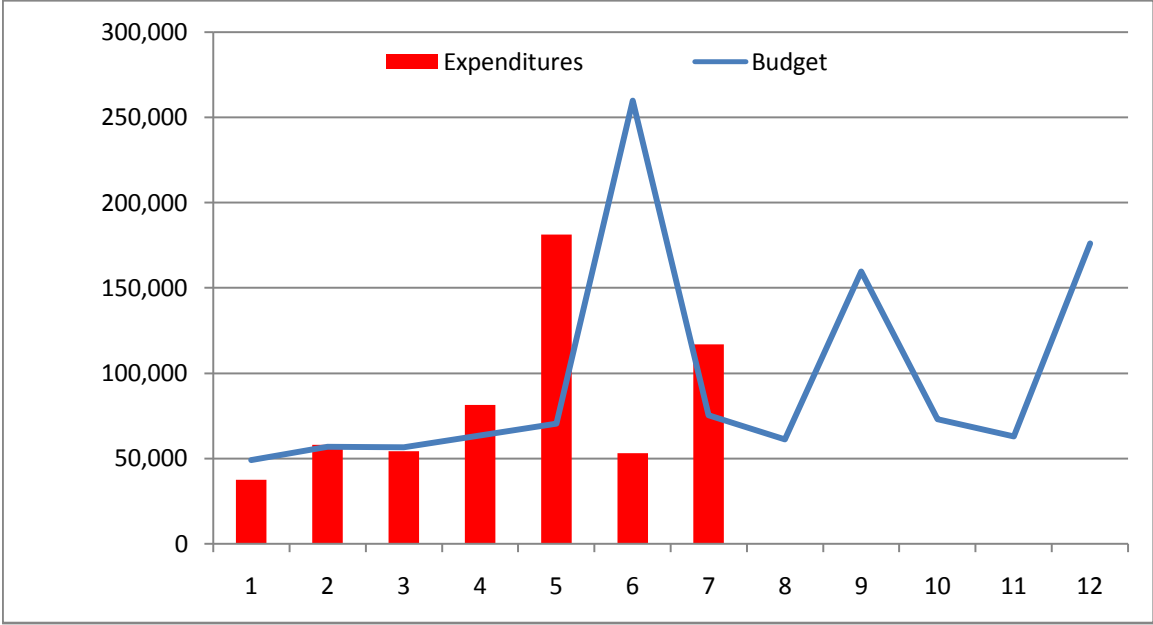
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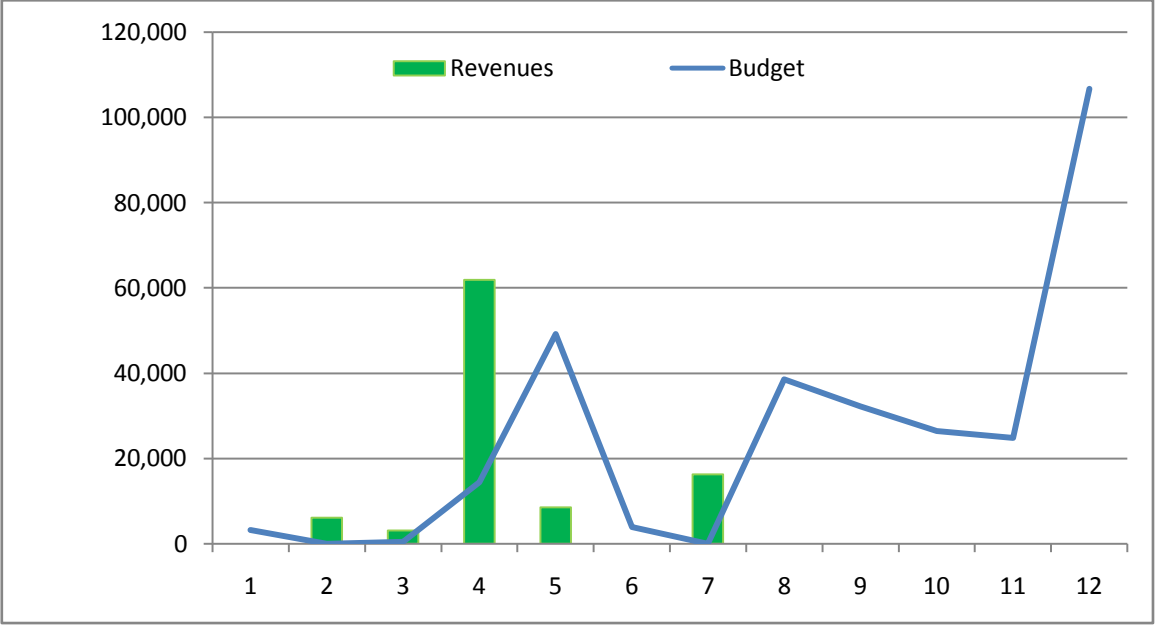
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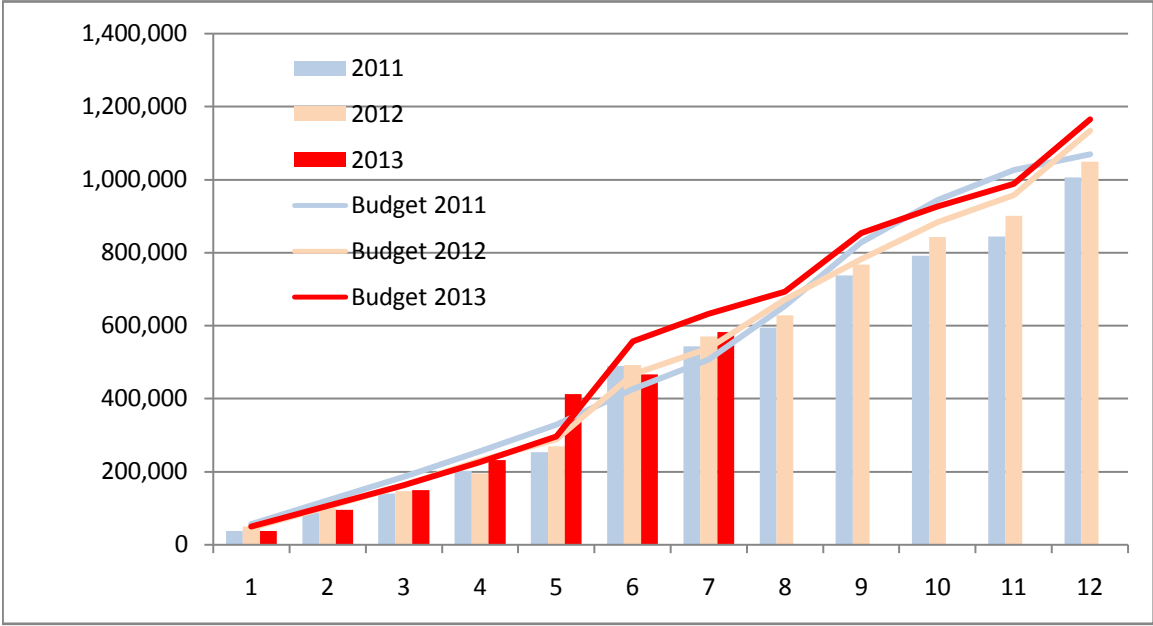
2013 Expenditures by month thru July



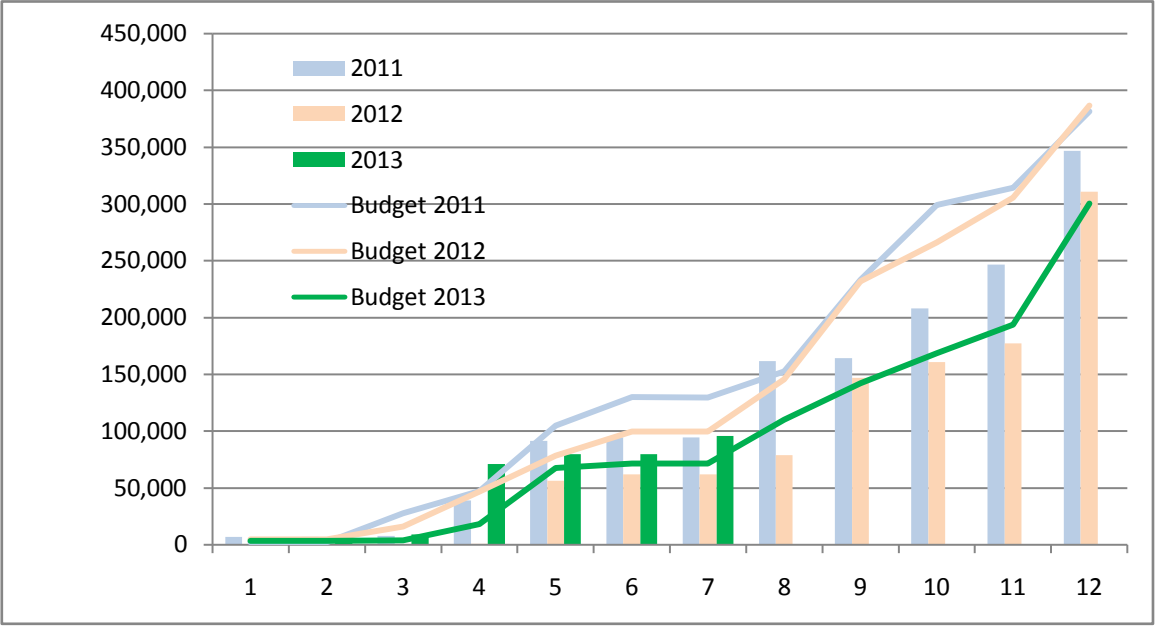
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

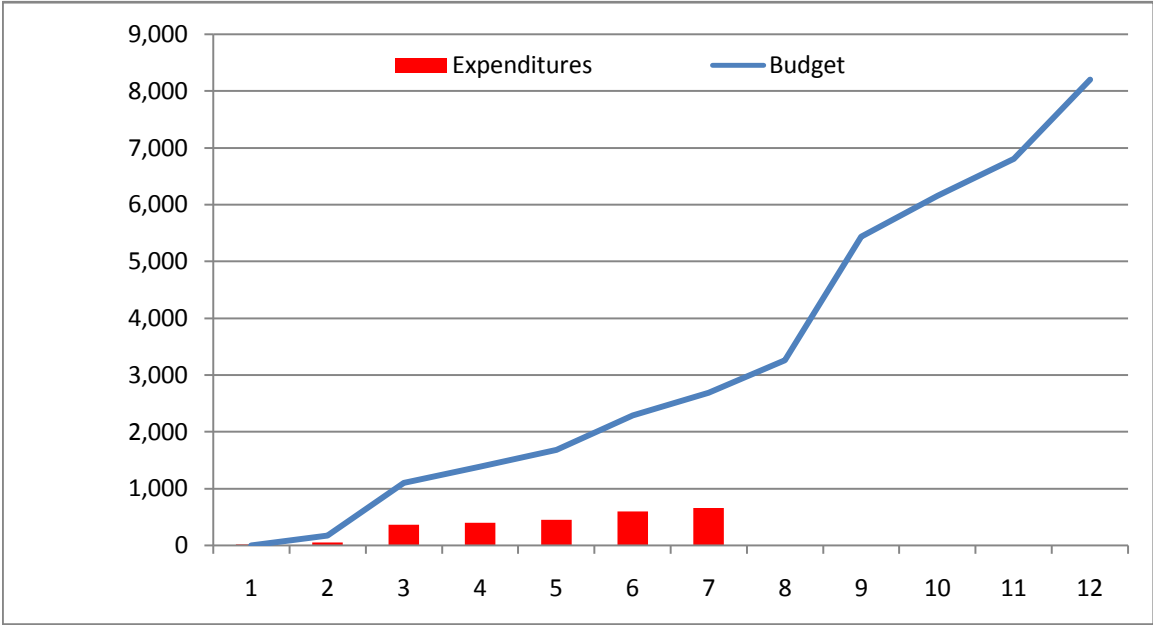


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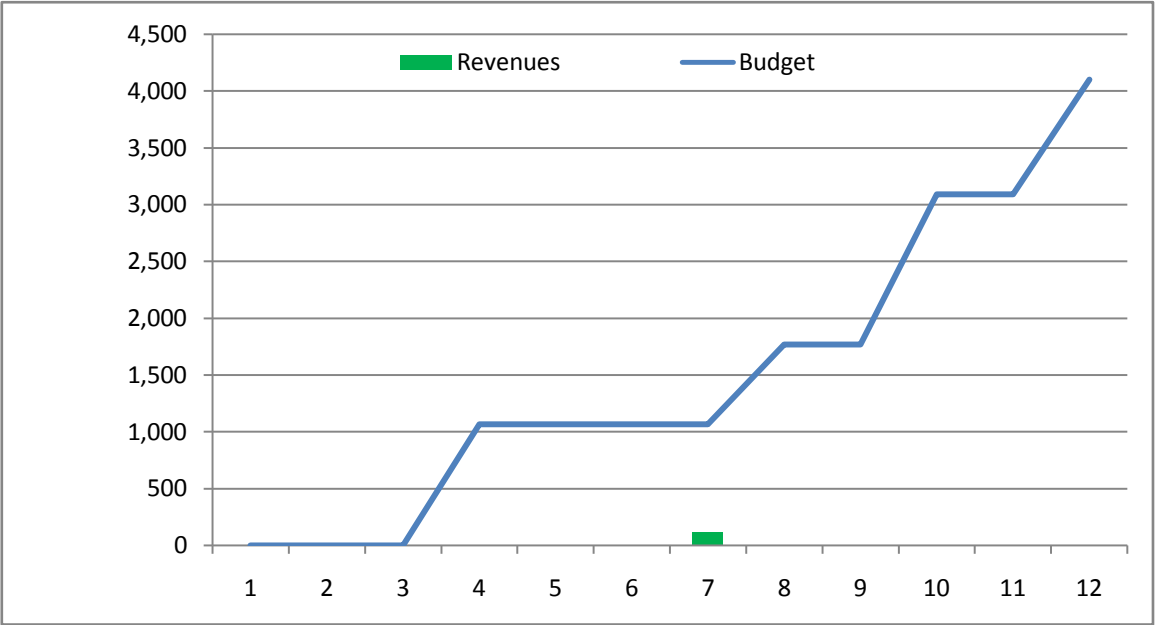
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Health Department - Phys.Handic.Chil.Treatment

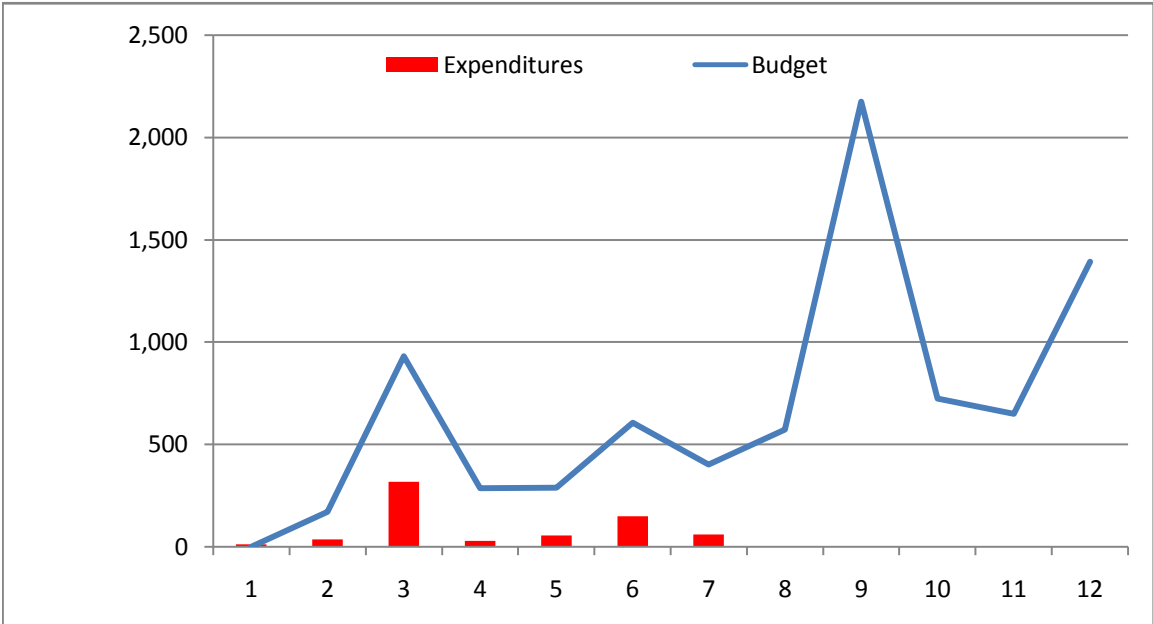
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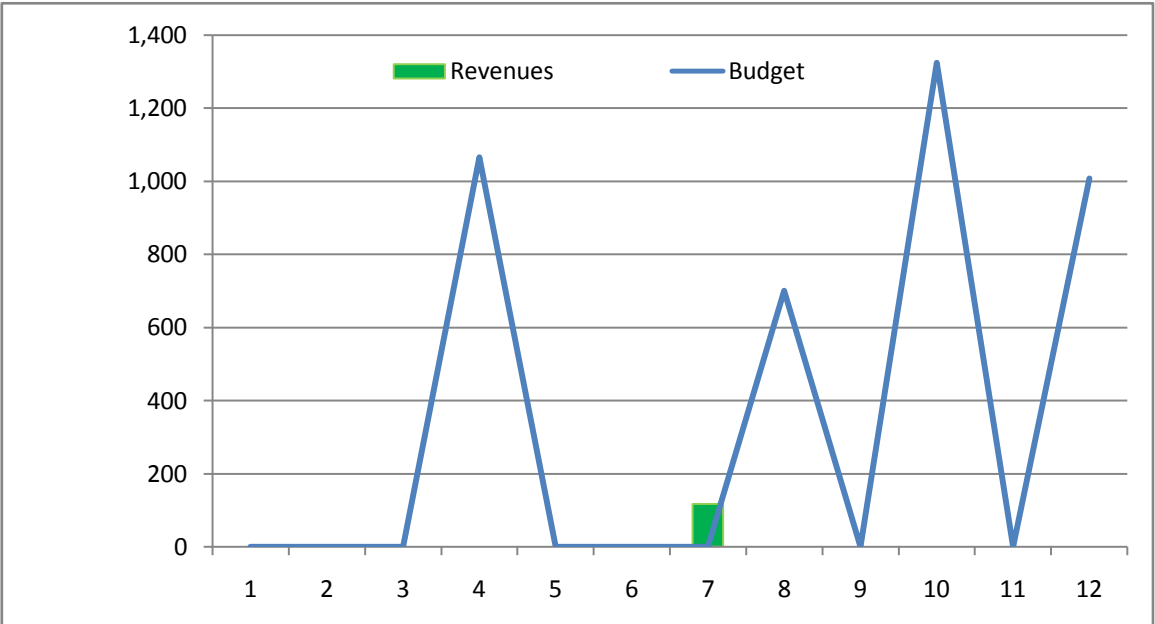
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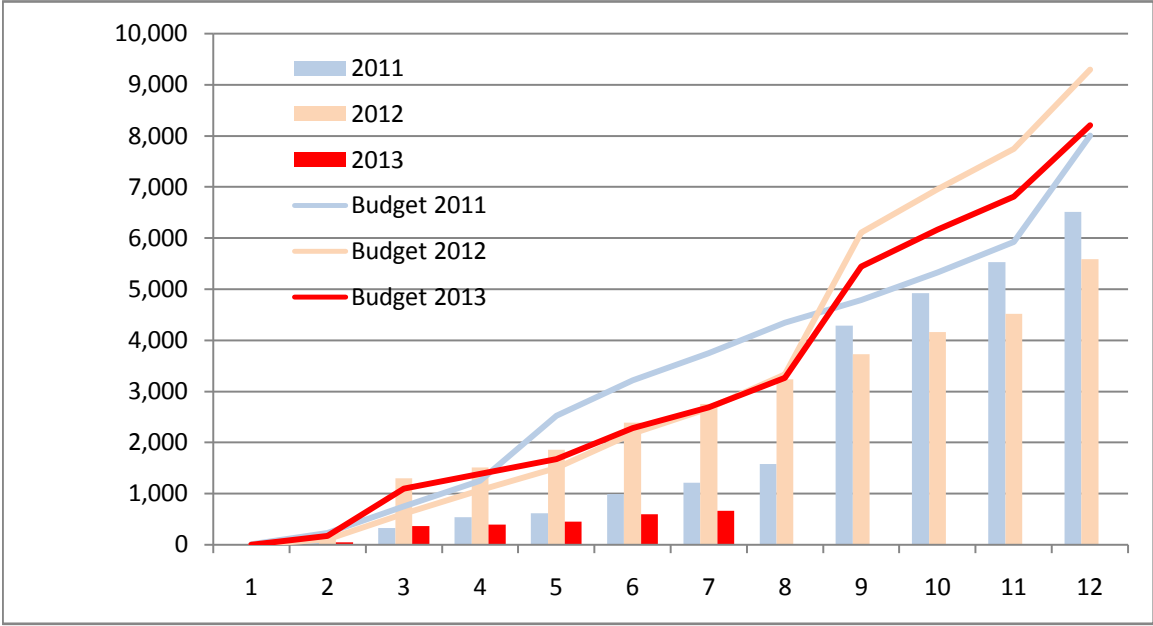
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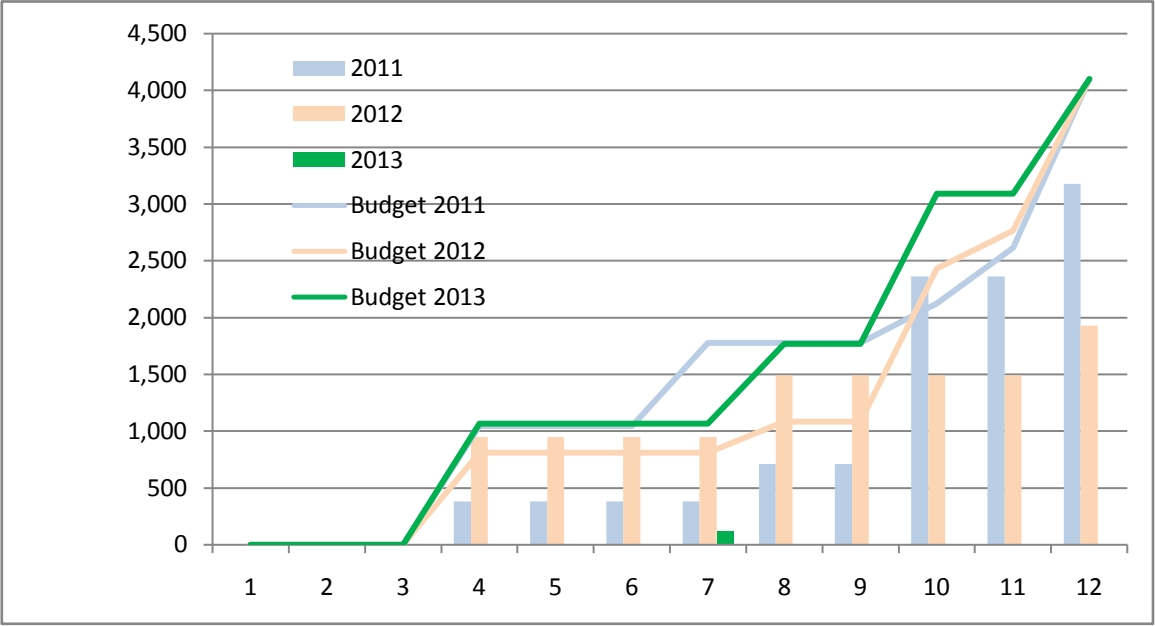
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Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

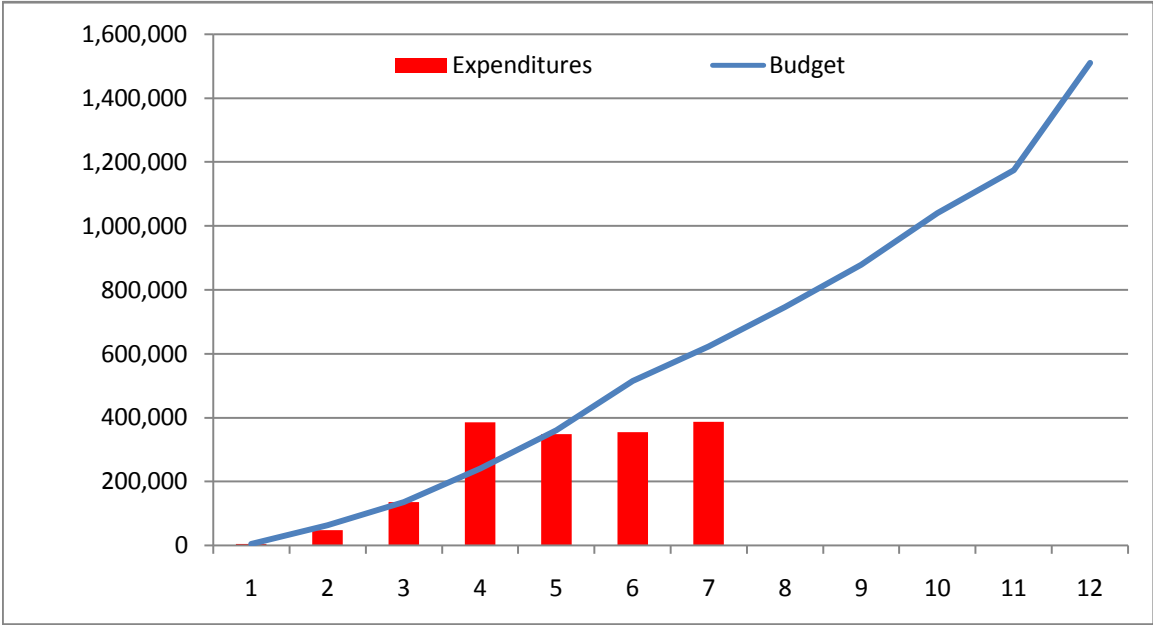


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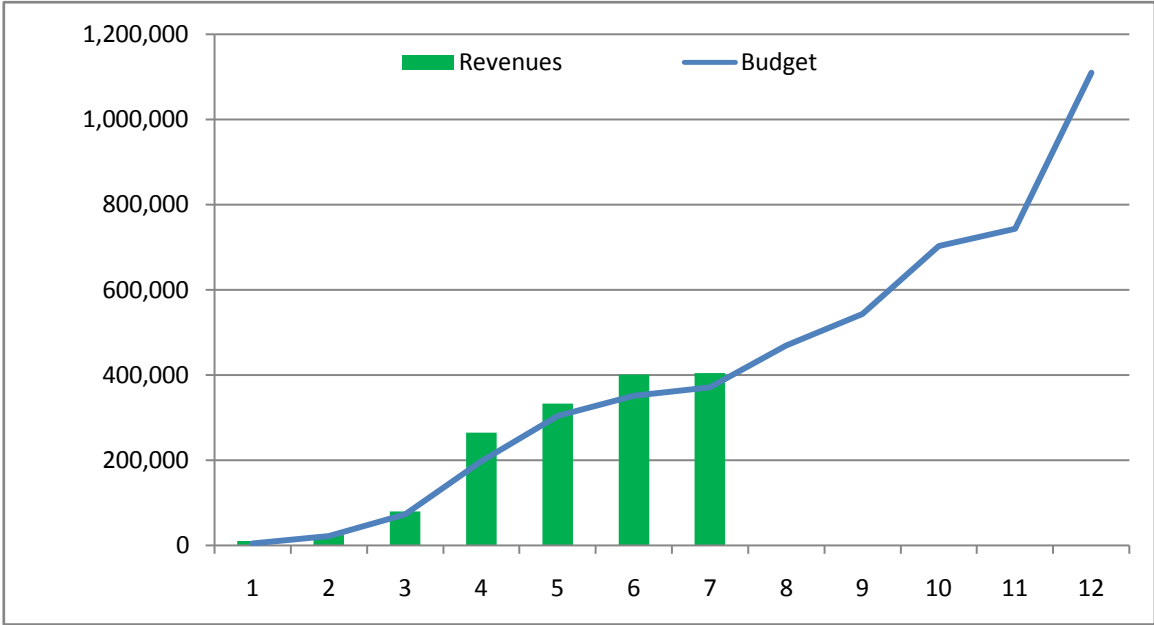
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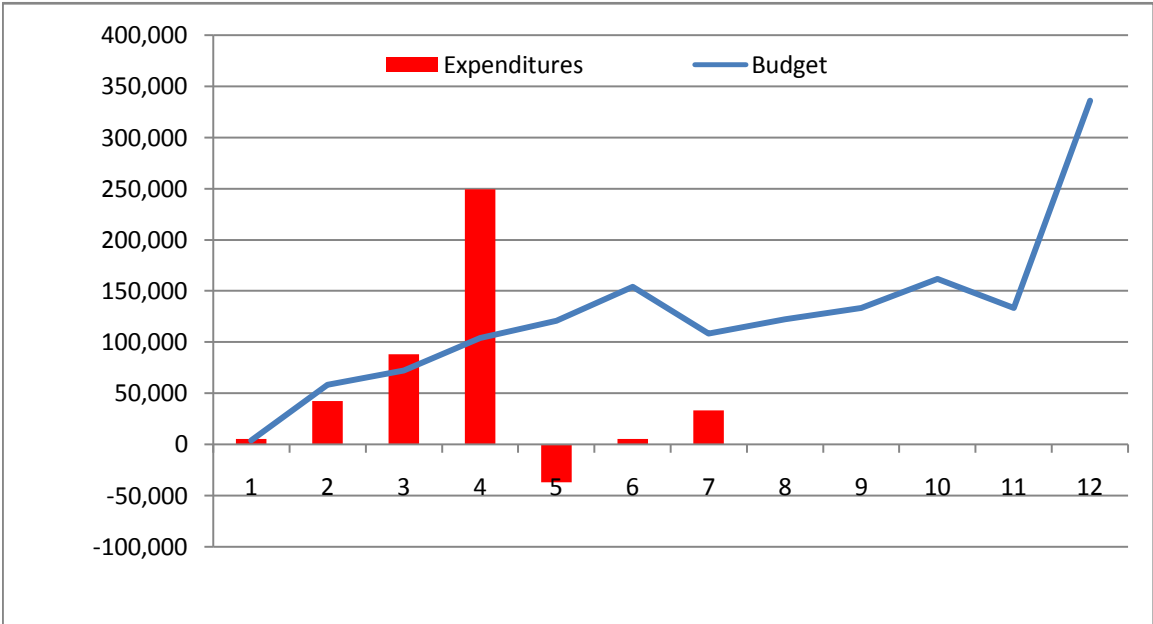
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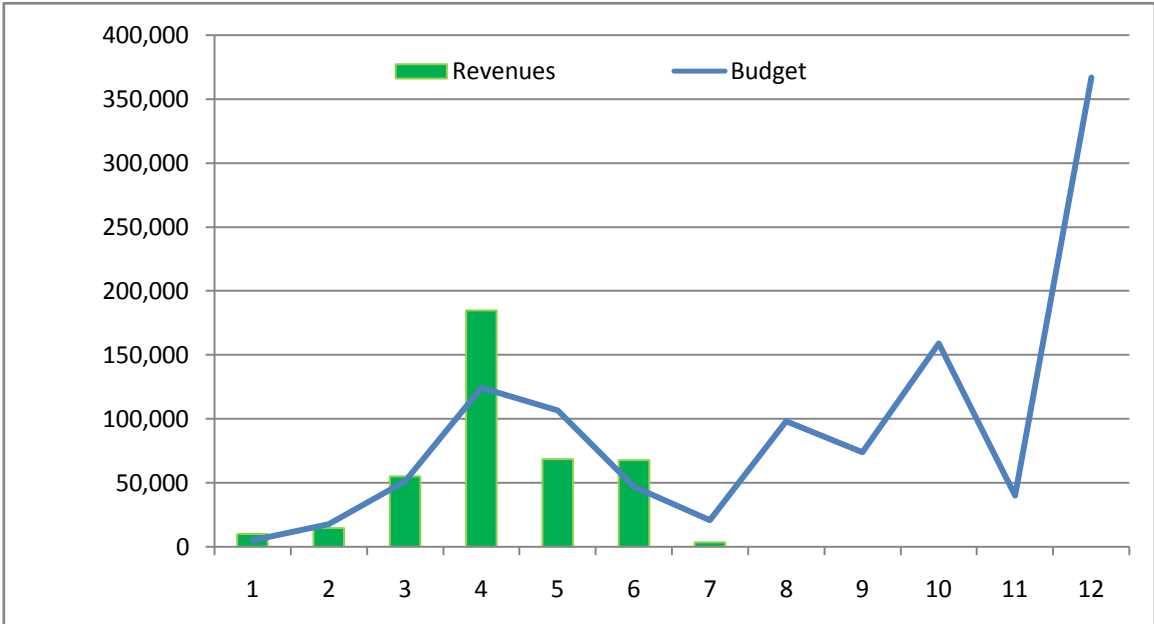
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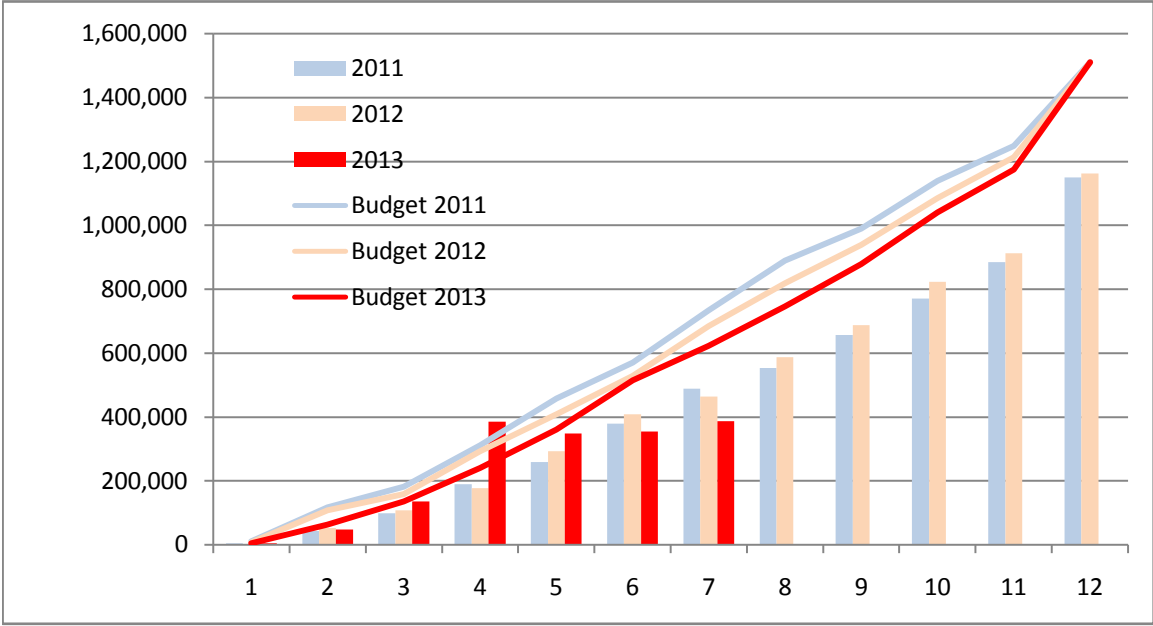
2013 Expenditures by month thru July



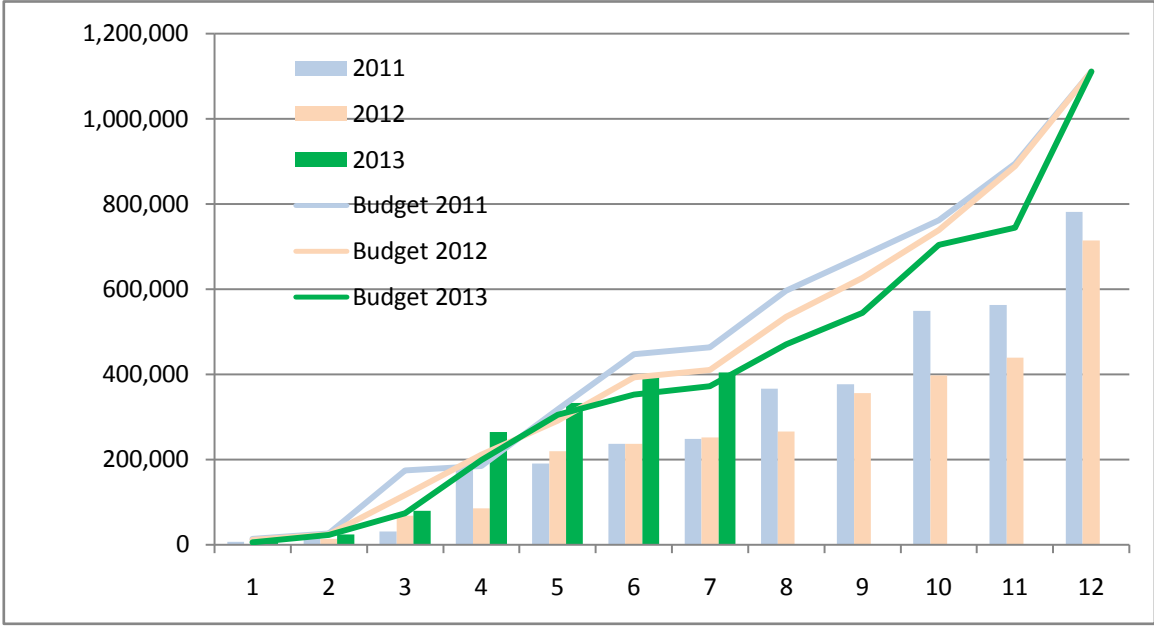
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

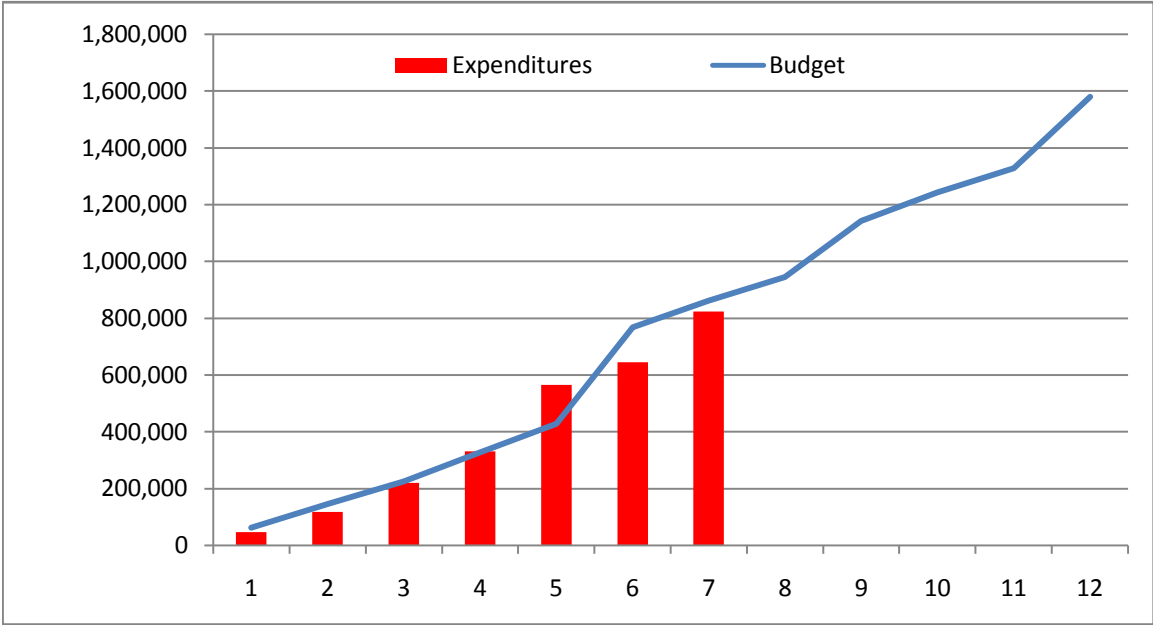


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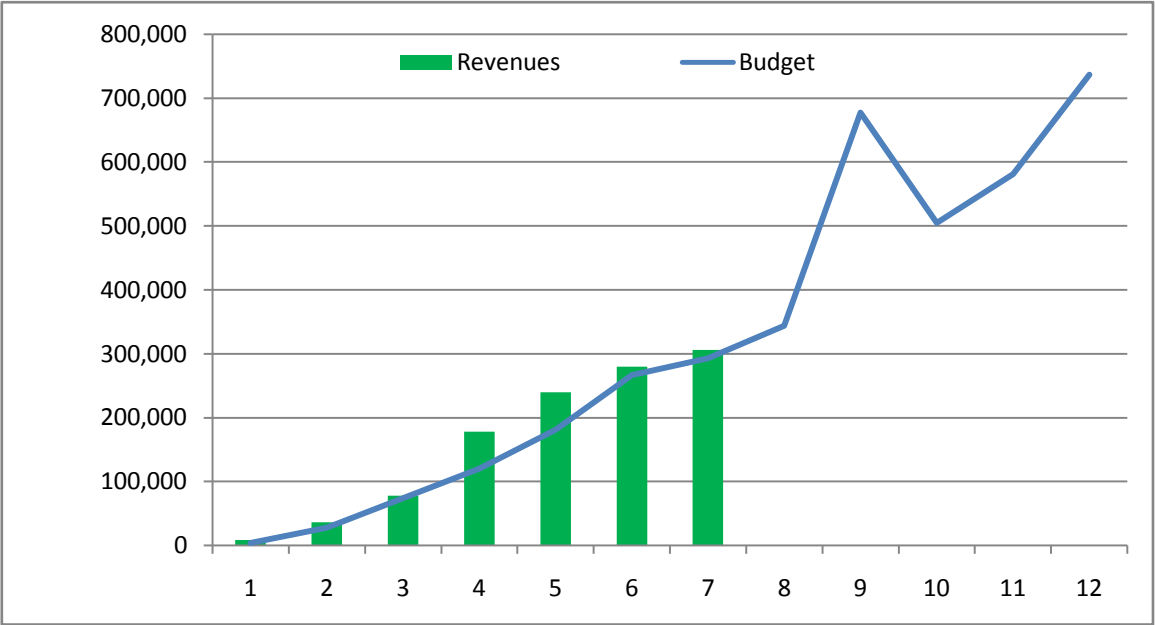
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Health Department - Environmental Health

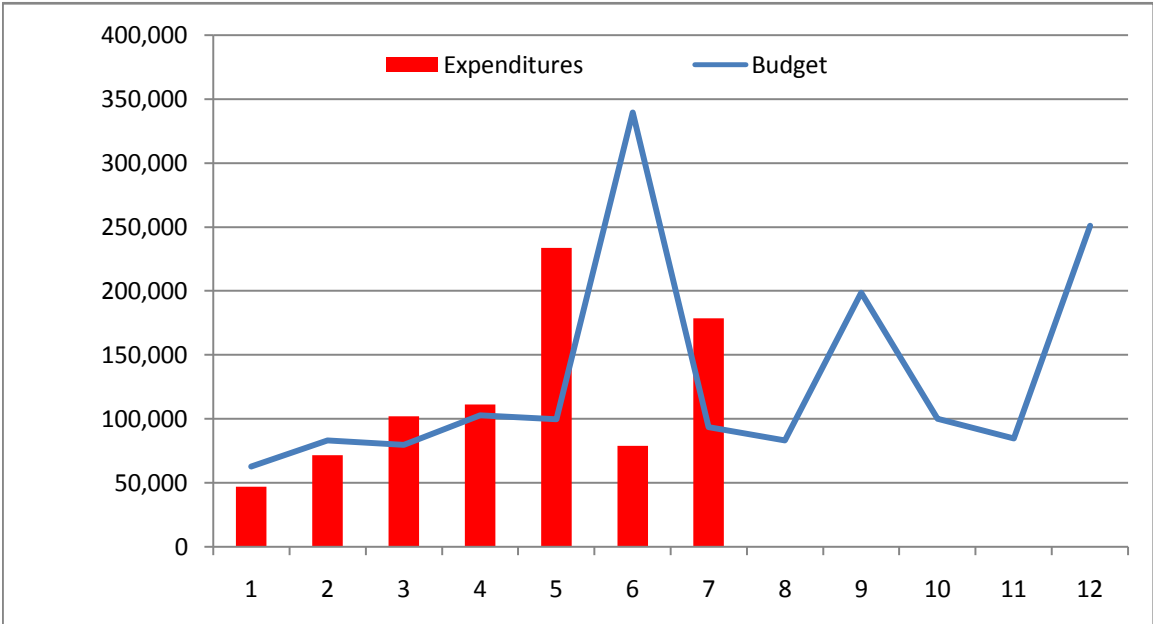
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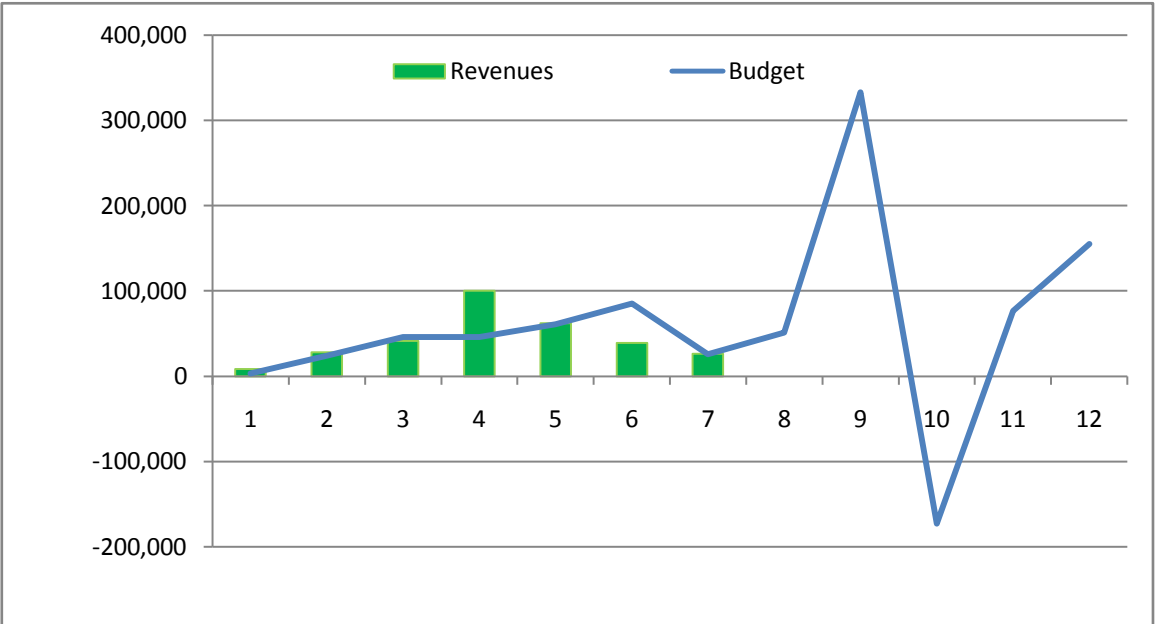
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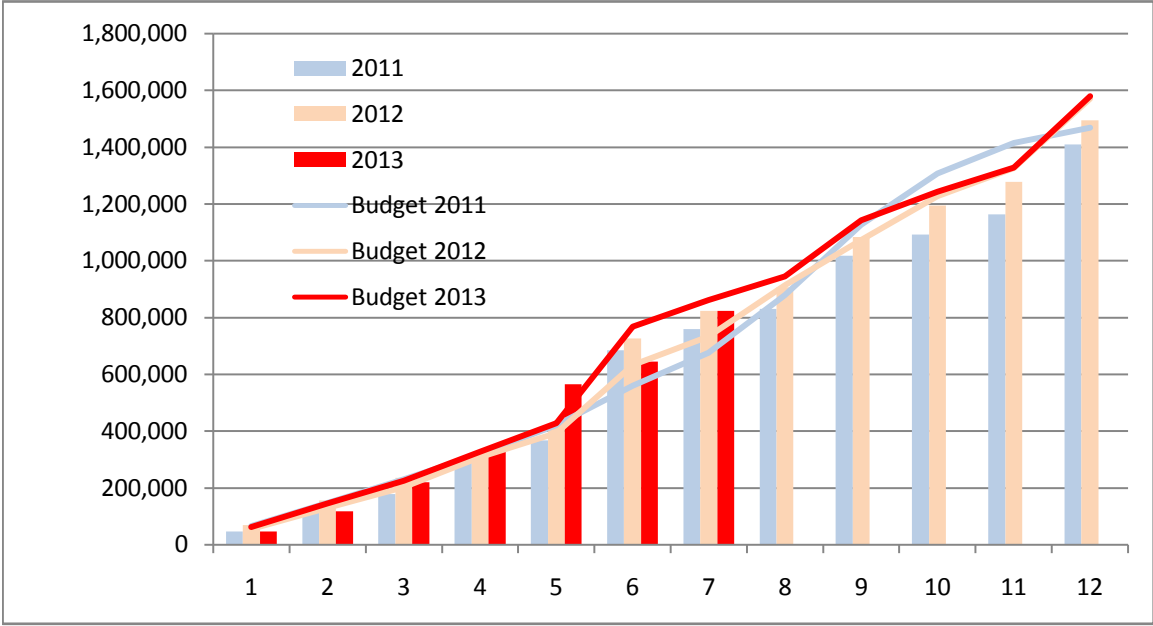
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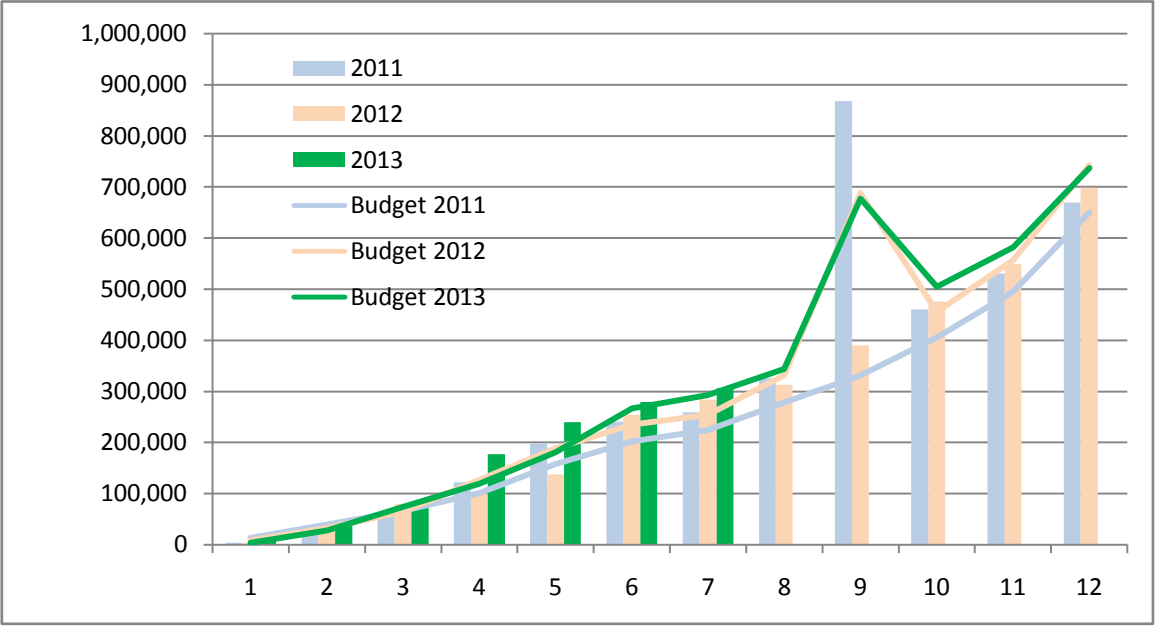
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Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013

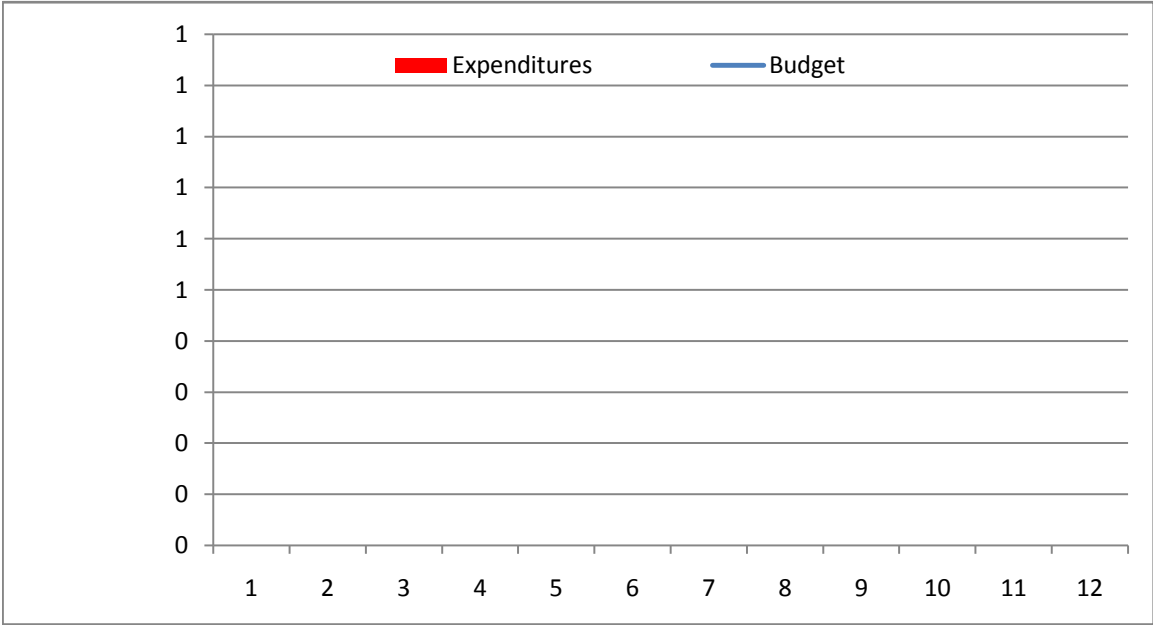


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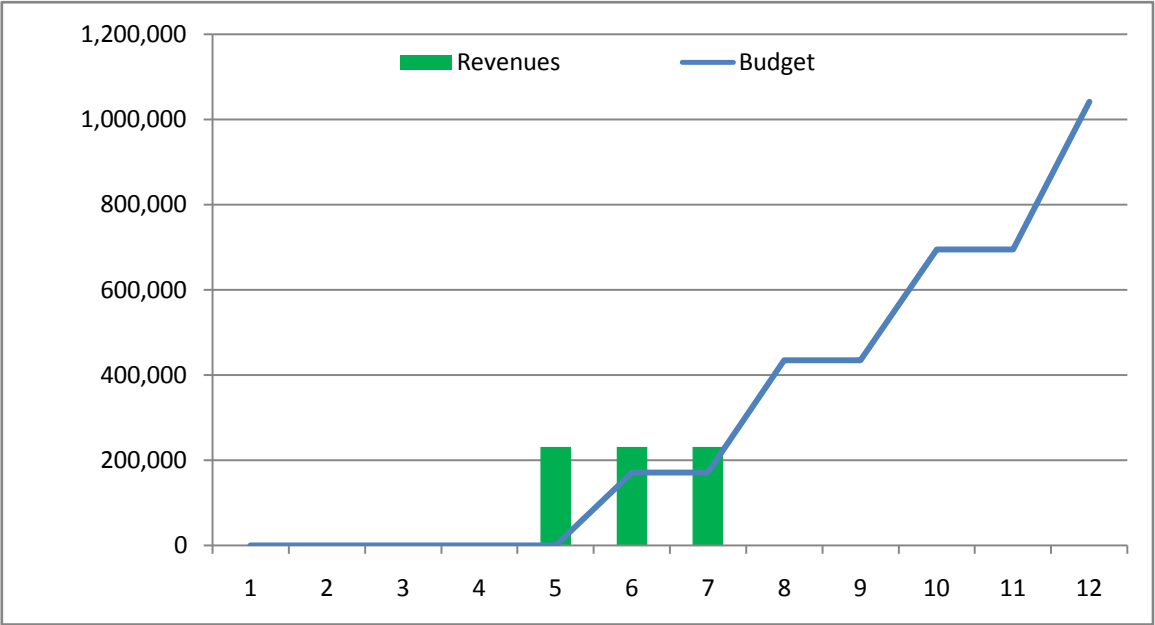
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Health Department - Public Health State Aid

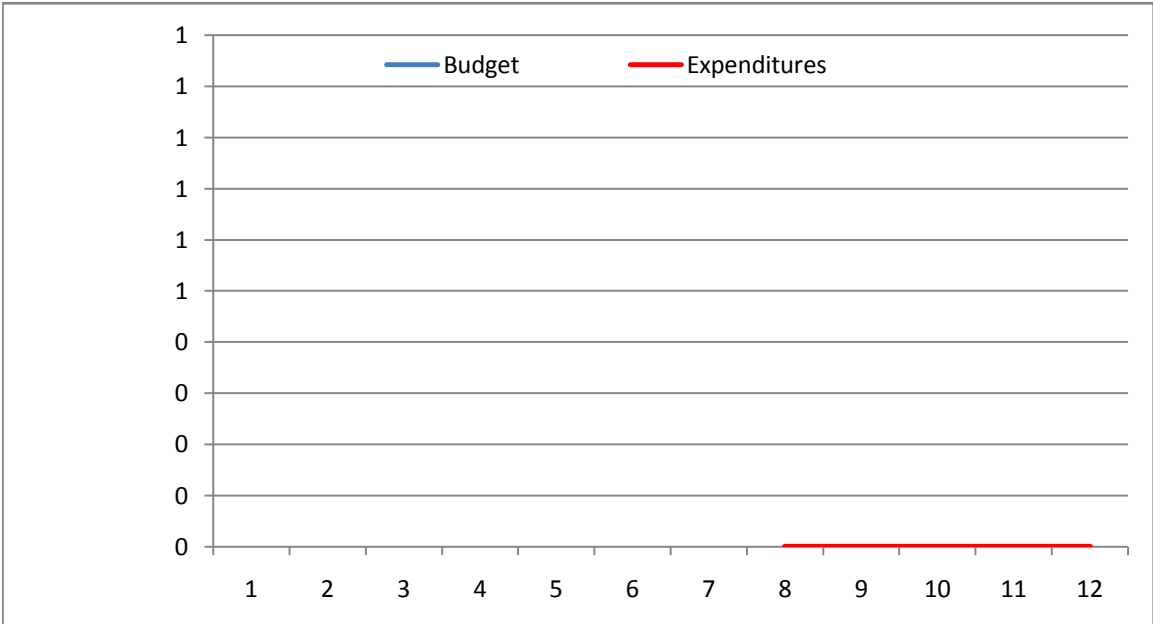
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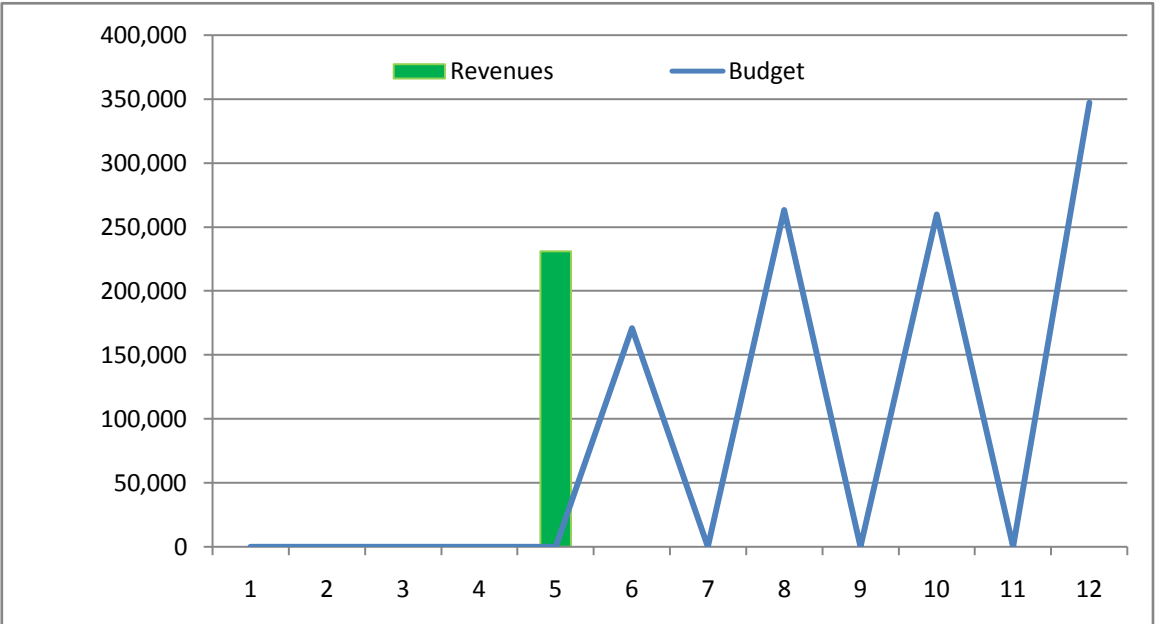
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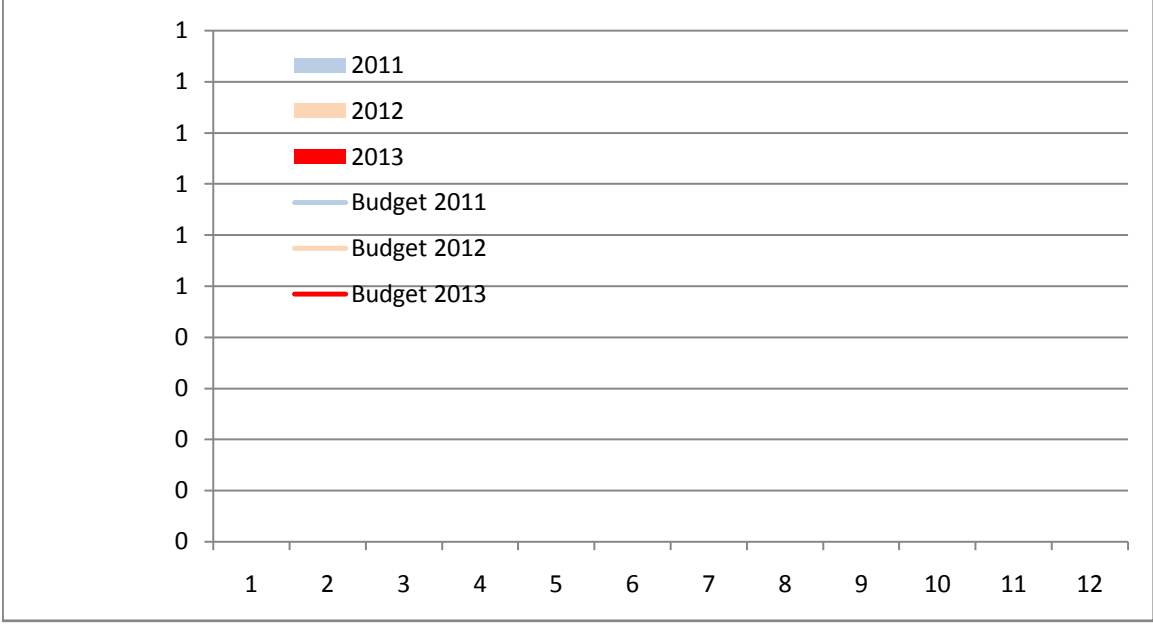
2013 Expenditures by month thru July



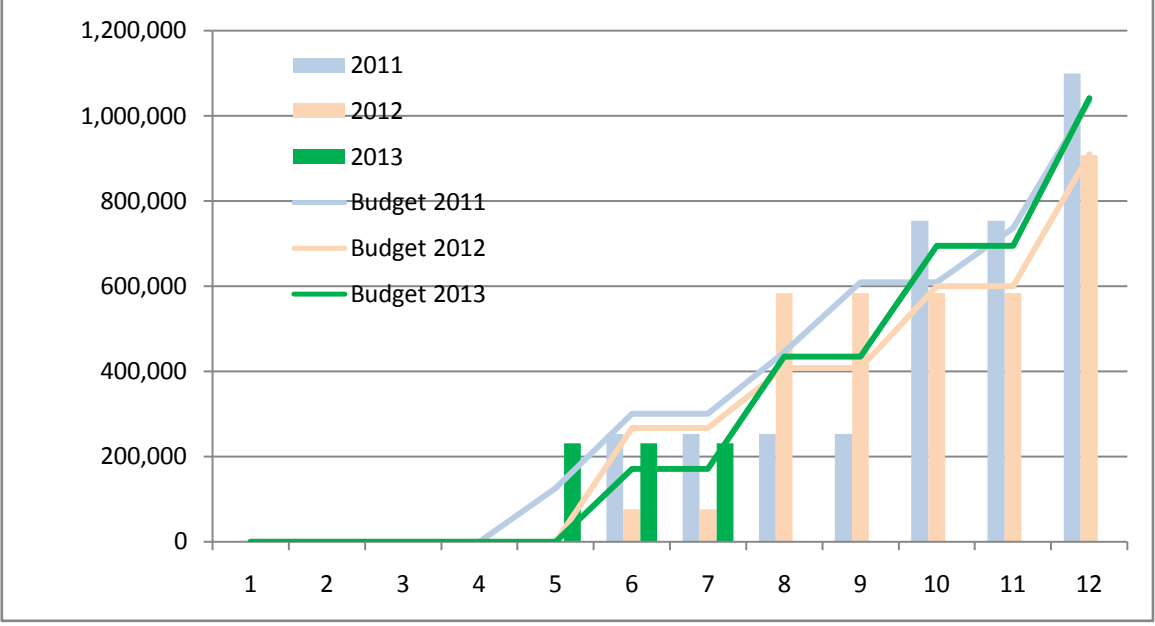
2013 Revenues by month thru July



Cumulative Expenditures by month thru July 2013



Cumulative Revenues by month thru July 2013



Notes:

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**Medical Director's Report
Board of Health
August 2013**

Review of NYSDOH Notifications:

A number of notifications have come in over the preceding months. There have been reported shortages of TB testing materials and also combination vaccine materials. Work-arounds have been formulated to work through these shortage periods until the products are back on line.

Concerns about influenza A virus H7N9 continue. The virus has been detected in China. The first cases reported on April 1st by the World Health Organization. There have not been any cases in the United States or elsewhere during this period of time. As of July there were 130 cases reported worldwide. While some mild illness in human cases was seen, most patients had severe respiratory illness and 43 people died. Close contacts of confirmed H7N9 patients were followed to determine whether any human-to-human spread of H7N9 was occurring. No evidence of sustained person-to-person spread of the H7N9 virus was found. No cases of H7N9 outside of China have been reported and the new H7N9 virus has not been detected in people or birds in the United States

This situation is being monitored closely by the CDC with the concern that the virus might mutate and increase its ability to transmit between mammals and humans.

H7N9 viruses do not commonly affect humans, so there is probably little immune protection that humans have against them.

Various scenarios are being prepared for, including the pandemic scenarios.

Among the initiatives that the CDC is developing are the creation of a candidate vaccine that could be used, as well as a test kit for detecting the virus. Communication with local health units and the practitioners is also of course part of the plan.

Middle Eastern Respiratory Virus:

The CDC received reports of the coronavirus type detected in the Arabian Peninsula. There was concern that this might come to the United States as cases had been reported from travelers in London. So far, the good news is that there have been no cases in the United States. Locally bulletins have gone out to area practitioners alerting them to this issue given the population that travels extensively.

Lyme Disease:

It occurred to me, since a lot of Lyme disease cases are diagnosed on clinical grounds (history and physical examination) and not on laboratory testing, that the department should encourage practitioners to increase reporting the clinical Lyme disease cases they diagnosis to supplement the back-up mechanism for reporting of the laboratory submitting positive test reports to TCHD independently of the practitioner. In cases in which a lab test is not done then the reporting back-up method does not apply and we rely solely on the practitioner making a report. I reviewed the methods by which we reach out to our practitioners again with Karen Bishop, RN. These methods remind practitioners to report clinically diagnosed cases and provide them with a check off form which will facilitate this and expedite the ease by which they may do it. But increasing clinical reports carries some problems with it in that our resources are limited to deal with the data.

The general perception is that Lyme disease has become more prevalent within the region. Let me review for you the basics of how Lyme disease is diagnosed so you can get a better idea why our resources have an impact on the information we have. The laboratory test that is used looks for antibodies to the Lyme bacteria, but it is of limited clinical usefulness; the lab data must always be interpreted in the light of the clinical context in which it occurs. History and physical examination are the keys to diagnosis. The history must include whether or not a tick bite occurred, whether the tick was likely to be of the ixodes type and how long the tick was attached to the individual, and whether there were any symptoms or a rash that occurred at the site of the tick bite. In addition, the time period between the time of the tick bite and the time that the person is being evaluated is of importance.

The decisions about treatment are based largely on these features.

Resources here at the Health Department are targeted to the prevention of disease by way of informing the public about preventive measures.

Lyme disease places different demands upon us compared to other diseases. Lyme disease does not pose a risk of spread from one person to another. So our prevention efforts are focused on educating the public to prevent exposure to Lyme disease, know how to deal with a tick bite, and to seek practitioner care to evaluate exposures that pose a risk. In contrast other diseases which have a risk of human to human transmission and therefore can have a multiplier impact on our community require direct staff intervention to break the chain of transmission.

We try to collect accurate information about Lyme's prevalence, but our data acquisition is limited by our resources. The staff in the division dealing with this data acquisition is challenged by not being fully staffed and lacking resources to even more aggressively reach out and collect data from practitioners in the area.

Data acquisition and manipulation is complicated and resource intensive. Laboratory reports of Lyme tests are automatically routed to TCHD staff when they are positive. But clinically diagnosed cases of Lyme which use no lab tests also come into the department along with ones that have used a lab test. Removing duplicates in order to have "clean" data is resource intensive. And, encouraging increased reporting of cases would increase the challenge. Given the lack of resources and the need to prioritize resources to diseases with human to human transmission, it is not possible to deal with Lyme disease in the way we would like.

Regarding prevention, a major message is to encourage the public to do "tick checks" of their body every day that they are in an environment where they might acquire a tick. 36-48 hours are required to transmit Lyme disease from the time of tick attachment to skin until transmission. If the tick is removed within that time period, the risk of acquiring Lyme disease is nearly zero. Thus our messages focus on removing ticks by doing tick checks frequently, as well as using the appropriate tick repellents and clothing to discourage ticks from being able to access skin.

Hepatitis C Screening and Testing:

The United States Preventative Services Task Force and the CDC (Centers for Disease Control and Prevention) have both agreed that routine screening of persons born between 1945 and 1965 should be offered at least once, in order to insure that these persons are not carrying the Hep C virus in an actively contagious state. It also will help to insure that they are not suffering chronic infection which can cause liver disease or failure.

Persons have a right of course to refuse this test.

This birth date target group was determined on the bases of epidemiological data which showed a higher than expected prevalence rate for this condition. This population has about 5 times the incidents of being Hep C virus carriers.

There are other high risk individuals who should be screened regardless of birth date. These include persons who are using intravenous drugs. Persons who are engaging in behaviors which would expose them to Hep C through blood (for example persons being pierced or tattooed by individuals not practicing accepted standards of care).

Sexual behavior in itself is a relatively low risk activity for Hep C transmission.

The general public needs to be aware that this screening is available and should be requested from their primary care practitioners and by practitioners caring for them at any level of care, especially if they have symptoms which might be relevant to their liver.

Practitioners are being made aware of this standard of care through their specialty websites and bulletins, as well as through the public health media which they receive.

One complicating factor is that not all health insurance plans cover the cost of this CDC recommended screening test. My experience is that about 50% of people will refuse the test due to its potential cost. About 40% will refuse it because upon reviewing the risk factors they do not see themselves being at risk. These groups overlap somewhat so the total refusal rate is about 50%.

Under the Affordable Care Act, all screening tests that are USPSTF rated “A” or “B” must be covered by insurance. This test is rated “B” by USPSTF and, thus, when ACA is in full force it must be covered by insurances.

In my view, the elimination of reimbursement issues for public health measures will increase their effectiveness through increasing their usage without compromising a patient’s privacy.

National Diabetes Prevention Program

I met with Theresa Lyczko and Susan Dunlop about the Health Department conducting classes based on this CDC developed product. TCHD is collaborating with the TC Health Care Planning Council to identify persons who are “prediabetic” and deliver to them an evidence based curriculum focused on preventing diabetes.

The initial focus is on lowering people’s calorie intake, particularly fat calories. Portion control is also emphasized and, later in the curriculum, a target goal of 150 minutes of exercise per week is introduced. Along the way a discussions about foods and their nutritional value are woven in.

So far the experience in Tompkins County has been favorable. A very large portion of attendees have achieved the targeted goal of a 7% weight reduction or more which in turn lowers their risk of developing diabetes.

Classes are offered here at TCHD for a fee to cover the 16 week course which is followed by monthly classes for a year. Measurements of the person’s Hemoglobin A1c (a test to measure average blood glucose (sugar)) are also done pre and post curriculum to document improvement or lack thereof.

Hydrofracking - Preliminary EPA Study in Pa:

The Post standard of Syracuse published the attached article on July 19th. I would like to make a couple of important points.

The Marcellus shale becomes shallower as one moves from the south to the north. This means that the fracking process occurs less deeply. In the counties of Tompkins, Seneca, and others of like latitude it may be occurring at about 3,000 feet.

The article states:

“The scientists also monitored a separate series of older gas wells that are about 3,000 feet above the Marcellus to see if the fracking fluid reached up to them.”

“The industry and many state and federal regulators have long contended that fracking itself won't contaminate surface drinking water because of the extreme depth of the gas wells. Most are more than a mile underground, while drinking water aquifers are usually within 500 to 1000 feet of the surface.”

And also:

“One finding surprised the researchers: Seismic monitoring determined one hydraulic fracture traveled 1,800 feet out from the well bore; most traveled just a few hundred feet. That's significant because some environmental groups have questioned whether the fractures could go all the way to the surface.”

And the final conclusion:

“The single study doesn't prove that fracking can't pollute, since geology and industry practices vary widely in Pennsylvania and across the nation.”

And, DOE spokesman David Anna added that while nothing of concern has been found thus far, “the results are far too preliminary to make any firm claims.”

Note that this preliminary study was south and west of Pittsburgh where the shale is fairly deep.

Thus, in NYS things could be different. We will be drilling more shallowly. Cracks may approach sensitive areas (including aquifers) more closely or actually invade them. We have a lot of uncapped defunct conventional wells that can become routes of exposure if hydrofracking invades them. These old wells will not have casings consistent with the requirements that DEC will, presumably, place on hydrofracking. Such circumstances could be one

of many Achilles heels in the chain of security to protect the public's health. (My apologies for the mixed metaphors).

The EPA staff doing this study (to my understanding) is composed of engineers and technicians. No public health people or medical people are allegedly involved in the study design.

On August 12th, the NY Times published an article on the landfill for NY City and the leukemia cases resulting from toxic chemicals and mismanagement of that landfill. More needs to be said about that type of tragic experience and all the others that have occurred (Love Canal, the nuclear storage site of West Valley in western NY, and etc.) to help the government, and the public understand why hydrofracking is no trivial matter. (See attachment)

“Perceptions of Public Health” – much work for us to do:

While Lezin et al's article "Perceptions of Public Health" was published a while ago (in 1998); it is not likely much has changed since then. Particularly enlightening was the study's finding that public officials including legislators and community leaders often have a limited understanding of the scope of public health.

By providing you with this 3rd article in as many months for your background reading I hope you will use it to help you promote TCHD's mission with the public. Hopefully, by being more fully informed, the public will be more motivated to support our efforts with resources that we need. (See attachment)

"The Invisible Nature of Public Health - implications for resources including funding":

Hoping not to overload you, I attach an essay to my report this month which also addresses the issues regarding resources. The writer is well known to me as you can see! Meg is our daughter. In the process of completing some required course work in order to apply to medical schools she took a course on Public Health taught by the former Commissioner of Public Health of the State of Vermont. Meg's essay received complimentary remarks from her professor and I think it summarizes for us some important issues. Perhaps

you will find it useful in your work on the Board. (Notice that it dovetails with the article I gave you last month by CDC Director Frieden which is also referenced in this essay.)" (See below)

EPA preliminary findings water supply Pa spring 2013

on July 19, 2013 at 1:31 PM, updated July 19, 2013 at 1:48 PM
Email

Pittsburgh (AP) -- A landmark federal study on hydraulic fracturing, or fracking, shows no evidence that chemicals from the natural gas drilling process moved up to contaminate drinking water aquifers at a western Pennsylvania drilling site, the Department of Energy told The Associated Press.

After a year of monitoring, the researchers found that the chemical-laced fluids used to free gas trapped deep below the surface stayed thousands of feet below the shallower areas that supply drinking water, geologist Richard Hammack said.

Although the results are preliminary -- the study is still ongoing -- they are a boost to a natural gas industry that has fought complaints from environmental groups and property owners who call fracking dangerous.

Drilling fluids tagged with unique markers were injected more than 8,000 feet below the surface but were not detected in a monitoring zone 3,000 feet higher. That means the potentially dangerous substances stayed about a mile away from drinking water supplies.

"This is good news," said Duke University scientist Rob Jackson, who was not involved with the study. He called it a "useful and important approach" to monitoring fracking, but he cautioned that the single study doesn't prove that fracking can't pollute, since geology and industry practices vary widely in Pennsylvania and across the nation.

The boom in gas drilling has led to tens of thousands of new wells being drilled in recent years, many in the Marcellus Shale formation that lies under parts of Pennsylvania, New York, Ohio and West Virginia. That's led to major economic benefits but also fears that the chemicals used in the drilling process could spread to water supplies.

The mix of chemicals varies by company and region, and while some are openly listed the industry has complained that disclosing special formulas could violate trade secrets. Some of the chemicals are toxic and could cause health problems in significant doses, so the lack of full transparency has worried landowners and public health experts.

The study done by the National Energy Technology Laboratory in Pittsburgh marked the first time that a drilling company let government scientists inject special tracers into the fracking fluid and then continue regular monitoring to see whether it spread toward drinking water sources. The research is being done at a

drilling site in Greene County, which is southwest of Pittsburgh and adjacent to West Virginia.

Eight Marcellus Shale wells were monitored seismically and one was injected with four different man-made tracers at different stages of the fracking process, which involves setting off small explosions to break the rock apart. The scientists also monitored a separate series of older gas wells that are about 3,000 feet above the Marcellus to see if the fracking fluid reached up to them.

The industry and many state and federal regulators have long contended that fracking itself won't contaminate surface drinking water because of the extreme depth of the gas wells. Most are more than a mile underground, while drinking water aquifers are usually within 500 to 1000 feet of the surface.

Kathryn Klaber, CEO of the industry-led Marcellus Shale Coalition, called the study "great news."

"It's important that we continue to seek partnerships that can study these issues and inform the public of the findings," Klaber said.

While the lack of contamination is encouraging, Jackson said he wondered whether the unidentified drilling company might have consciously or unconsciously taken extra care with the research site, since it was being watched. He also noted that other aspects of the drilling process can cause pollution, such as poor well construction, surface spills of chemicals and wastewater.

Jackson and his colleagues at Duke have done numerous studies over the last few years that looked at whether gas drilling is contaminating nearby drinking water, with mixed results. None has found chemical contamination but they did find evidence that natural gas escaped from some wells near the surface and polluted drinking water in northeastern Pennsylvania.

Scott Anderson, a drilling expert with the Environment Defense Fund, said the results sound very interesting.

"Very few people think that fracking at significant depths routinely leads to water contamination. But the jury is still out on what the odds are that this might happen in special situations," Anderson said.

One finding surprised the researchers: Seismic monitoring determined one hydraulic fracture traveled 1,800 feet out from the well bore; most traveled just a few hundred feet. That's significant because some environmental groups have questioned whether the fractures could go all the way to the surface.

The researchers believe that fracture may have hit naturally occurring faults, and that's something both industry and regulators don't want.

"We would like to be able to predict those areas" with natural faults and avoid them, Hammack said.

Jackson said the 1,800-foot fracture was interesting but noted it is still a mile from the surface.

The DOE team will start to publish full results of the tests over the next few months, said Hammack, who called the large amount of field data from the study "the real deal."

"People probably will be looking at the data for years to come," he said.

On Friday, DOE spokesman David Anna added that while nothing of concern has been found thus far, "the results are far too preliminary to make any firm claims."



Meg Klepack
May 25, 2013

The Invisible Nature of Public Health

In this paper, I will argue that the American public is not bored by public health. Rather, I believe that the field of public health is invisible to the general public. This invisibility is built into the very structure of the public health system. With its emphasis on implementing environmental changes to prevent disease, the public health field acts largely behind the scenes, away from the public eye. When outreach has been a component of a public health campaign, messages have received insufficient media attention or been insufficiently funded to create wide-spread public awareness.

Public health initiatives are most effective when they change the environmental conditions in which we live and least effective when they rely on individuals to change behaviors.¹ In 1999, the CDC compiled the 10 greatest public health achievements of the 20th century, citing improvements in sanitation, drinking water, roads, and food safety as critical advances to preventing disease and injury.² The public health initiatives behind these advances created the systems to ensure safe drinking water flows from every faucet, grocery shelves are stock with foods free from pathogens, flours are enriched with key nutrients, salt is iodized, tap water is fluoridated, and cars are designed to protect their passengers. These systems-level advances have allowed millions of people to live longer and healthier lives, without ever being aware of the vital public health protections in place.

The power of systems-level change is demonstrated even in issues such as tobacco use. While tobacco use is conventionally thought of as a personal decision, public health measures have demonstrated that environmental changes, including the price of cigarettes

and bans on smoking in public venues, are far more effective at reducing rates of smoking than educating individuals about the dangers of smoking.³

The effectiveness of the systems-level approach means public health officials often prioritize working behind the scenes, where their work is invisible to the general public. Ali S. Khan, director of the CDC Office of Public Health Preparedness and Response, spoke to this in stating, “When public health is invisible, it means we've done our job successfully. Typically, the only time it is visible is when something new arises or when something has gone wrong.”⁴ As a result, the general public not only takes public health measures for granted, but loses sight of the fact that they are public health measures in the first place. As a result, there is widespread confusion in the general public about the realm of public health.⁵

In some public health initiatives, public participation is a key strategy – vaccinations are a good example. Here too, though, the realm of public health remains largely invisible. Education and implementation of immunizations typically occurs when people access healthcare. As a result, public health vaccination initiatives are confused for healthcare.

While the work of public health is largely behind the scenes, public health officials recognize value in communicating their work with the public – both to offer educational resources about disease prevention and to share the success stories of their work. This communication is challenging and can often times fail to reach its intended audiences in meaningful ways for the following reasons:

Public health officials can have a challenging time getting their stories and messages out through the traditional media. The media landscape, dominated by stories of the latest

crisis or scandal, often gives short shrift to public health's success stories of prevention. In addition, priority public health campaigns remain largely the same year to year. As a result, public health messages can become stale and are therefore easily ignored by both reporters and the general public.

Public health messages can also fail to engage their audience due to their technical nature. Public health is a field rich in data. Public health messages run the risk of remaining technically accurate while failing to emotionally connect with their audience.

Finally, in these times of tight budgets for all government agencies, marketing campaigns are likely to be under-funded. Officials that must prioritize tight budgets are likely to target marketing funds before cutting programming.

While the implementation of public health initiatives is most effective at the systems level, the institutions of public health must do a better job of making their work visible to the general public. As government bodies, public health organizations are inextricably part of the American democracy. As such, their funding levels will always be subject to the politics of appropriations. Efforts to cut "big-government" spending threaten public health budgets. A well-informed public, aware of the vital role that public health plays in their lives, is the best hope public health has for maintaining (or increasing!) spending on public health. Additionally as anti-vaccination and anti-fluoridation campaigns spread misinformation and degrade the public's trust in public health, public health officials must communicate more widely about their work. Public understanding of the roles and goals of the public health system, and transparency of public health officials about their work, are vital to maintaining and building a strong, publicly supported public health system.

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